Let’s Put an End to What Blocks Providers and Patients from Controlling Health Care Costs

written by Theresa Hush | June 19, 2025

We often blame providers for not controlling health care costs. We also put the onus on patients who overuse care inappropriately and make bad choices. But the fact is that control of health care costs is extremely complicated, and we have effectively blocked both providers and patients from controlling health care costs.

Since the birth of managed care, providers and commercial health plans have been sparring over money and access to patients. Every health plan renegotiates its payment rates with providers on a contract schedule. Insurers try to hold down the payment rates based on a variety of factors—how important the provider is in the local market, the provider's cost profile, quality, and so on. Providers gauge the importance of the payer to their revenues, evaluate payer claims denials, and calculate related administration costs.

Price Negotiations and Lack of Price Transparency Have Cost Us All

Providers and payers have alternately won and lost in negotiating prices, but the negotiation process itself has cost plenty—to patients, employers, government, and society. It has driven health systems and the health insurance industry each to consolidate, in order to overcome the advantage gained by the other, raising and not lowering costs. It has also raised administrative costs for the whole system to manage the rate structures, contract management, billing, coverage and medical necessity policies, patient eligibility, and administrative machinery.

For several years, the system of rate negotiations between payers and providers has also stood in the way of two key paths to control the cost of health care. The first is price transparency to patients, necessary for making decisions about their care. Insurers don’t want patients to have access to that information because true transparency would reveal their negotiated rates, which would damage their negotiating position and standing with employers.

The second problem is insurers’ unwillingness to provide detailed digital claims data to providers for all services generated for their patients, so that providers can better create strategies to control the cost of patient care. This is data that would help everyone achieve the benefits of lowered costs, but that’s not a priority for insurers, because making

that data available to providers would be a disadvantage to rate negotiations.

Let’s examine what makes this negotiated data so important for providers to be able to control costs.

Value-Based Care Requires Data-Driven Strategies to Control Costs

Every aspect of Value-Based Care depends on using data to measure and improve performance, whether in cost or quality.

Payers (except for CMS for specific value-based payment models), resist providing digital claims data that extends beyond the services of the specific provider. They often have dedicated payer portals whereby providers look up reports on their costs, and often this data is aggregated and benchmarked. It does not permit line-item cost details that could be plugged into providers’ databases and integrated with EHR data.

Providers are blind to services outside their own and often blind to diagnoses and other conditions that patients may have. Although large EHR companies, like Epic and Health Information Networks, have created capacity to identify patients across systems, this is lacking in cost information and details of service that would help providers identify cost drivers, see complications and other detail in patients’ histories, and import this data into Value-Based Care platforms used for managing costs. The data is geared to individual clinician

management of patients at point of care, not for analysis of care costs.

As a result, providers' ability to develop cost strategies is impaired, and they cannot fully evaluate cost drivers, utilization, complications, and comorbidities in their patient data.

Key Elements of Data-Driven Cost Strategies

Managing cost of care through data-driven strategies is novel for providers. In the past, cost reduction strategies focused on inputs to care, not the cost to payers and patients. Addressing input costs (e.g., salaries, medications, anesthesia, equipment) can help reduce overall costs, but these are usually one-time fixes. They also don't transfer to pricing or negotiated payments of providers for patient care. Health care costs equal those paid out by payers *and* patients, collectively known as the total cost of care (TCoC), or per patient costs of care (PPCC).

Lowering TCoC requires reducing resource use through *improvement* in patient care. It's a complex process to ferret out the causes of escalating costs. It is not helpful to compare pricing, which bears a tangential relationship to the direct cost of care for any patient. The most effective way to analyze TCoC is to compare actual patient cases for a given condition, treatment, or procedure, in order to evaluate the differences in costs and the component costs. Episodes of care, the analytics vehicle for looking at patient cases, requires

longitudinal clinical data from the EHR and complete transactional claims data for the patient.

Without claims data from payers, providers are missing a huge piece of information for analytics that see cost and patient outcomes in the same episode. This is critical because a second, ineffective method to reduce resources is to provide poor care. Poor care will result in higher costs, either immediately or over time, as evidenced by patient safety events, unsupported diagnoses, complications, and disease progression.

The broad adoption of EHRs and mandatory quality reporting has increased adoption of digital health records throughout the health systems, and fortified providers with high quality clinical data. This empowers providers to use analytics and data-driven solutions.

But if providers can’t see the full picture of a patient’s health, they are hampered from tackling costs along with quality. The cost and services detail that comes from payer claims completes the patient profile by adding history, other provider information, and services. Clinical and claims sources together unlock the power of provider strategies to control cost of care.

Three Possible Solutions to Break the Impasse

Both payers and providers could benefit from reducing cost of care, but they’re stuck. Providers have the most to gain by

trying to resolve the issue, since risk reimbursement will put them at a huge disadvantage without the tools to manage costs. Here are three strategies that may help

1. Use a third party to aggregate the payer data.

Your data vendor already has your trusted EHR data. If that vendor also has the experience and ability to craft Value-Based Care Episodes in a way that can satisfy payer concerns by bundling some of the Episode costs without destroying integrity of the cost investigation, this is much to your advantage.

2. Use standardized fee schedules, like CMS, for cost data.

This option is of much lower value to cost investigation. But it does enable the development of clinically focused episodes based on EHR clinical and transactional information, so that analytics can be very informative to physicians on cost variation and other outcomes data. Patient admissions and ER use will still be included in the same record, as will prescribed medication data, but without cost data. Regardless, it is a good beginning step because the construction of an episode is complicated, requiring many decisions on inclusions and exclusions of data. Creating such episodes and later incorporating claims data is an advantageous strategy.

3. Negotiate specialty projects with payers for collaboration over shared claims data for patients in project cohorts.

This could be a solution for specialty-rich organizations to

streamline and collaborate on specialty cases that frequently have claims denial issues. If providers can work out a solution to payer issues and achieve the ability to build cost control strategies based on improved dialogue and agreement on clinical pathways, this could provide an opportunity for both providers and payers. It might also help to chip away at payer hesitation to share claims data in the future.

The current CMS administration has reinforced the concept of price transparency for patients for both payer and provider data. Does this signal that, perhaps, current payer resistance to price transparency will no longer be tolerated? Probably so. Now is a good time for providers to be seriously waging a new collaboration with payers. It would be in everyone's best interests.

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Image: Morgane Perraud

Roji Health Intelligence Achieves HITRUST e1 Certification Demonstrating Foundational Cybersecurity

written by Evelyn Herwitz | June 19, 2025

Roji Health Intelligence LLC, a leading provider of Value-Based Care technology and services to health care providers, today announced that its Roji Clinical Data Registry, ”Roji

Registry”, has earned certified status by HITRUST for foundational cybersecurity.

Roji delivers services to reduce the cost of health care and improve patient health through its technology, based on aggregating data from provider’s clinical record systems and insurance claims.

HITRUST e1 Certification demonstrates that the organization’s Clinical Data Registry – Roji Registry is focused on the most critical controls to demonstrate that essential cybersecurity hygiene is in place. The e1 assessment is one of three progressive HITRUST assessments that leverage the HITRUST Framework (HITRUST CSF) to prescribe cyber threat adaptive controls that are appropriate for each assurance type.

“In today’s environment, it’s imperative that organizations like ours keep pace with current and emerging threats,” said Theresa Hush, CEO at Roji Health Intelligence. “We are pleased to demonstrate to customers that they can trust in the stewardship of their patient data through HITRUST e1 Certification.”

“The HITRUST e1 Validated Assessment is a good tool for cyber-aware organizations like Roji Health Intelligence that want to build assurances and progressively demonstrate due diligence around information security and privacy,” said Robert Booker, Chief Strategy Officer at HITRUST. “We applaud Roji Health Intelligence for their commitment to cybersecurity and successful completion of their HITRUST e1 Certification.”

About Roji Health Intelligence LLC

Roji Health Intelligence LLC provides Value-Based Care technology and services to health systems, Clinically Integrated Networks, Accountable Care Organizations, and physician groups. Roji has worked with hundreds of organizations to help clients achieve success under new models of value-based reimbursement. Click here for more information about Roji Health Intelligence and to schedule a call to learn more about how we can help you control costs and improve outcomes.

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Multi-Payer VBC Strategy Is Essential for Cost Control, but Providers Must Get a Fair Deal

written by Theresa Hush | June 19, 2025

To meet its goals of controlling costs and improving patient care, Value-Based Care requires a near-universal, multi-payer strategy.

5 Things I Learned from Speaking at the Spring Managed Care Forum

written by Theresa Hush | June 19, 2025

One of my favorite professional activities is to speak to a broad health care audience and get feedback on their response to reform initiatives. Last week I spoke at the Spring Managed Care Forum in Orlando, Florida. The Fall and Spring forums are a favorite venue for me, and I never fail to get new information about what people, especially physician leaders, are thinking.

My talk was about controlling the costs of health care. I've spent a good part of my career addressing health care costs in one role or another—as a regulator, an employer, a payer, a health system executive, and in technology and consulting. As Value-Based Care and its payment models matured over the years, however, cost control was not the primary focus, MSSP ACOs notwithstanding. While savings may be rewarded, most programs have used the carrot rather than the stick and capped provider risk for higher expenditures.

Value-based payment models put greater focus on quality measurement and reporting. Primary care payment models, while introducing a gradual path or small element of risk, also provided investment and infrastructure. Following COVID, models to improve health equity emerged. The primary cost feature in all new models is a feature that will gradually replace Fee-for-Service payments with either population-based or episode-based payments. But these have been carefully constructed to be modest adjustments.

Cost is now front and center. I presented a more sobering view of the economics of improving care in an environment of budget cuts. I described the payment models in place to control the Total Cost of Care (TCOC) or Total Per Patient Costs (TPCC),

and what providers and payers need to do to make them work. I polled attendees about whether they thought Value-Based Care could produce effective cost control, and I spoke to people after my talk about their impressions. You can access my slide deck here.

Here's what I learned:

Many physician leaders are optimistic about the ability of Value-Based Care to control the total cost of care. While there are indeed some who believe that value-based payments will kill the system, the majority in my audience believed in the power of these new tools to positively affect the system.

Supply of physicians, both primary care and specialists, is the biggest issue that concerned physician leaders. With success under value-based payments determined by data-driven technology, more communication with patients, and the deployment of clinical teams, physicians are justifiably concerned. Not only is there already a shortage of physicians, but some of the budget cuts on the table reduce payments for medical education and residency programs that build the supply. The viability of health systems, hospitals, and physicians are all at risk under this shortage, regardless of ability to add alternative clinicians, population health staff, artificial intelligence, and other technologies.

Another supply-side fear is exodus of providers from the Medicare program under lowered or risk-based reimbursement, especially those with the potential effect of lowering revenues. I received comments about physicians leaving for

concierge practices, retiring, and refusing Medicare patients. This is, again, a realistic fear based on a scenario of distinct differences in reimbursement for Medicare and private health plans that CMS will need to address.

Among federal budget cuts, the loss of NIH research, CDC programs, and data available to guide clinical care are the biggest threats to the health care system, as perceived by physician leaders. Some expressed that these cuts will ultimately lead to wasteful spending and higher costs.

Medicare Advantage as an alternative to Traditional Medicare is very unpopular with many physicians. The attendees saw physicians fleeing Medicare Advantage because of prior authorizations and claims denials, and the costs of participating in a program that requires fighting to get paid.

I share this feedback because it shows how much the community of health care providers really believes in a system to provide good care, and that they have a stake in its outcomes. Sometimes we are slow, and cautious. But like them, I share an optimism that health care wants to improve and provide the best for patients.

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Image: Tulip Sunflower

Why Hospital Giants Are the Next Battleground in the War on Costs

written by Evelyn Herwitz | June 19, 2025

Hospitals are just emerging from several years of post-pandemic planning and correction, when sustainability was the overriding issue. Now consolidation has driven up costs—largely by improving health systems' negotiating power. Indeed, most studies show that after mergers, whether vertical, horizontal, regional, or national, the costs are higher.

New federal budget proposals on the table are poised to cut health care, and these cuts will target hospitals, especially academic systems. That puts consolidated hospital systems in a real bind. At the same time, hospitals are now the major employer of physicians, while the number of physicians nationwide is shrinking, and burnout is further exacerbating the shortage.

Add to that an aging demographic that over the next decade will shift the payer mix toward Medicare and away from commercial payment, a trend that will have profound effects on hospitals' bottom line.

These dynamics are going to force risk-averse hospitals into a different role in Value-Based Care, centered on reducing costs. In this interview on The Hospital Finance Podcast®, Roji CEO Theresa Hush speaks with Kelly Wisness about what's at stake and how health systems can position themselves better in Value-Based Care.

https://www.besler.com/insights/the-value-based-care-reckoning/
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3 Essentials to Cut Health Care Costs Without Cutting Patient Care

written by Theresa Hush | June 19, 2025

There is an understandable fear and a little outrage right now about health care budget cuts. Some proposed cuts will raise the amount of unfunded care for hospitals and physicians if Medicaid coverage is reduced, and impact patients in nursing homes. Other proposals will eliminate offsets for medical debt or physician education through residency programs. While not directly affecting Medicare benefits, these proposals affect the bottom line of hospitals and health systems, and all patients and coverage programs will bear the brunt.

Providers’ lack of engagement in cost control must change. While the industry claims to be experts about health care and its costs, the slow adoption of risk payment models in Value-Based Care has precipitated a crisis in costs that requires immediate correction. The only way to change it is for

providers to get out in front on cost control.

A “Scarcity” Approach to Cutting Health Care Costs

Traditional approaches to trimming health care costs involve a mix of cutting patient services while expanding revenues. Prior authorization denies patients coverage for services advised by their physicians. Take the trend of cutting obstetrical services, which has become a common approach to cost management that leaves patients without access to necessary care.

A charge for asking your doctor a clinical question on the EHR portal expands revenue, but it also limits patient engagement that was once seen as positive. So too, concierge fees for faster access to your doctor increase revenues to avoid cutting patient care, but limit who can afford to be seen.

These are Scarcity approaches to health care cuts. While we know that health care costs are out of control, these are not the best strategies for managing costs. They do nothing to improve the real value of health care. Over time, Scarcity approaches diminish not only your contribution to health care, but also your most precious resource—your patients’ trust.

If this mindset prevails, health care could go the direction of airline travel, where even choosing airplane seats requires calibrating the benefits of additional foot room with the price of travel. Is that really what we want?

3 Ways an “Abundance” Approach Will Achieve Value Without Reducing Services

Instead, we can approach health care cost control with an Abundance mindset. Abundance is the route of Value-Based Care. Overall cost—and revenues—are constrained by payment models. We do more with less by allocating services according to a “top of license” approach, directing resources toward the highest risk patients, engaging patients in care for better outcomes, deploying technology for value, and solving problems before they occur.

Let’s examine how to control costs within the Abundance context. To better manage or even reduce resources, you need to deploy strategies to initiate change in the relationships between key parties: clinicians and their patients and support system, and the information flow between them.

But you can’t create strategies that achieve cost control and better value unless you have alignment with your patients’ expectations of what they *should* get from you. In other words, you can’t control costs if you and your patients are not in a trusting relationship. Any cost initiative will fail if you have not taken care of these three essentials:

1. Implement clinical teams led by physicians, other clinicians, and personnel to support complex patient care.

Without support, physicians end up without the resources to improve outcomes and prevent utilization events under value-based payment models. While many ACOs and health systems have separate support systems in population health and utilization management, these often do not work in concert with clinicians, leaving the physician to bear the burden of failure in a fragmented system. Patients and their support partners need to understand who is in charge and how to engage with them.

With a clinical team approach, individual functions are delegated to team members to support the physician-patient relationship and treatment plan. These include contact with the patient, determination of patient needs for more intensive communication, preparation of patient information, preparation of patient self-management programs and enrollment of patients, specialty referral follow-up, monitoring of patient clinical status, patient decision-making materials, and treatment cost information. None of these functions can be reasonably performed by physicians if we are trying to ensure a “top of license” approach that ensures that the clinician focuses on medical needs, and the supporting members of the team engage in the matters that feed into the pool of information and decisions.

2. Prioritize two areas of cost control: chronically ill, high-risk patients, and specialty care.

There will always be unanticipated costs and patients in

trauma. If you have developed a clinical team approach, these will be handled within that context. But the greatest pounding on costs inevitably builds from two pressure points: patients with chronic disease, especially those whose conditions are not well controlled, and specialty care services. There is overlap between these two, but each will require strategies.

Lowering costs can only be achieved by creating systems through a combination of data and initiatives. In the interests of reducing costs enough to meet your bottom line, it makes sense to go after the largest patient populations and/or largest dollar services. Your goal is not to eliminate these services (the Scarcity approach) but to improve outcomes at lower cost (the Abundance approach). For instance, you can target patients with chronic illness and behavioral health issues, which have higher emergency and inpatient admissions, to proactively reduce chance of complications. You can create a risk-centric pool of patients with multiple conditions, exacerbations, and prior utilization to help pinpoint those who need attention, to ward off an expensive crisis (in every sense of the word).

For specialty services, you will almost certainly need to target your major referred groups, if you are a primary care practice. These will usually include Orthopedics/Neurosurgery, Cardiology, and Oncology. Your goal is much the same: improve the per-case cost by avoiding complications and “redo’s” and collaborate with specialists on complex medical management and shared decision-making.

3. Align your patient care with patients' expressed needs.

Part of the "cost" of doing health care includes missed opportunity with patients. You might call it a lack of "patient compliance", but the issue is much bigger. It can include wavering trust in you, lack of information about the benefits or harms of treatment, challenging financial or other patient circumstances, health care literacy, not enough time. Better communication is essential to traverse this territory. Members of the clinical team can carry the weight of this effort, with training, inclusion in patient care, compassionate listening, and consistent messaging.

Patients say they want price transparency, honesty, and information. They want access to care when they need it and clear answers to their questions. They don't want to hide their own concerns and circumstances—but they may be inclined to, if they don't feel heard or respected in a conversation.

In short, you can't "do" cost control without establishing and maintaining a trusting relationship with patients, to increase the odds that they call you before going to the emergency room or ask for your guidance before making a decision with a specialist.

To use a positive airlines analogy, cost control in Value-Based Care starts with a familiar line heard on every flight: "We understand you have a choice, and we want to thank you for flying with us today."

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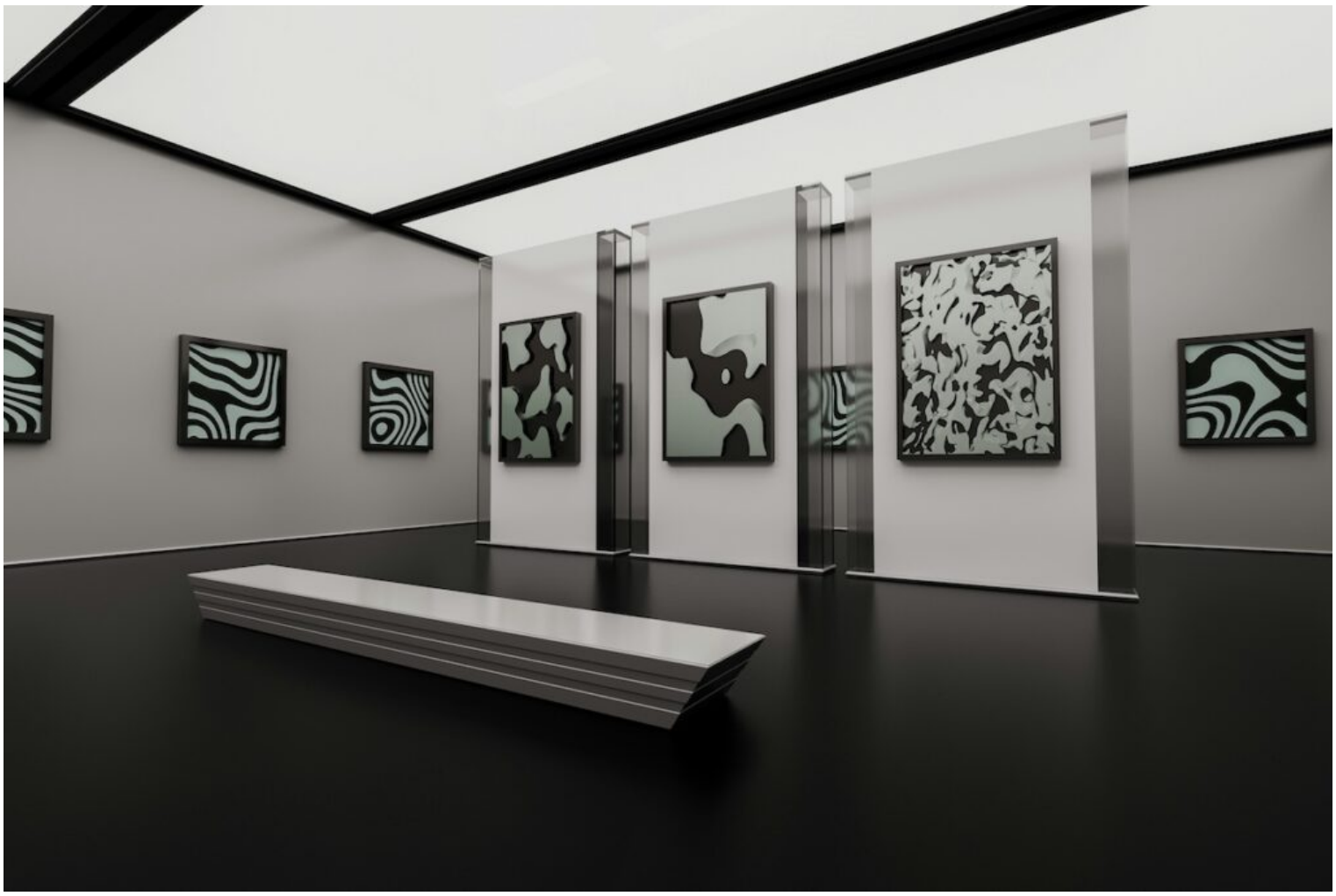
Image: Abhishek Singh

Curate Your Data to Tackle Cost of Care: Master These Basics

written by Theresa Hush | June 19, 2025



The staggering reality that health care could soon account for one fifth of all domestic spending has put a bull's eye on health care cost control. Is your ACO, health system, or physician organization ready to manage the coming congressional budget cuts? The only effective way to tackle Total Costs of Patient Care (TCoC) without cutting services is through a curated Value-Based Care approach. Here are the fundamentals you need to know and five strategic steps to formulate your approach:

What Is the Total Cost of Patient Care?

As a provider, you may think of your patient as generating costs. Or, you may think of your own cost outlays to provide care. Those factors figure into your internal budget and pricing, of course. But under Value-Based Care payment models (and also Managed Care contracts), the Total Cost of Patient Care is a tally of expenditures for a population of patients who are attributed to your providers. In other words, TCoC is defined by the market/customer. It equals your total payout in expenditures through claims. Because the definition applies to a population of patients, out-of-network claims are usually included in TCoC.

TCoC places responsibility on the provider to manage costs of care. Not only your own costs, but also your specialty referrrals, your care plans, your admissions and treatments are included in TCoC. The derivative of Total Costs of Patient Care, or Total Per Patient Cost (TPPC), is how the market puts pressure on you to evaluate and reduce costs under various payment models and contracts.

The TCoC approach creates vulnerabilities for provider organizations. Under network consolidation, providers have expanded their patient reach and will be vulnerable to more patients needing specialty care. For ACOs, TCoC will change depending on how patients are attributed to your providers; if you include specialists, you may be more exposed to higher total patient care costs. We will focus on how to manage TCoC and TPPC through Value-Based Care.

Is Claims Data Enough to Identify Cost Opportunities?

If claims data is the basis for TCoC calculations, why shouldn’t it be enough for examining cost? First, let’s examine what special benefits you gain with claims data from payers:

- If claims data is complete with diagnoses, provider details, sites of service, and prescription and other costs, it will give you the basis for calculating TCoC.
- It will provide a view of your admissions and emergency visit data, so that you can examine admissions and length of stay, and use that data in population health.
- Medicare data will give you HCC risk adjustment scores, which may be helpful in defining patient risks.
- Your out-of-network costs and providers will be illuminated.

However, claims data, alone, is not sufficient for TCoC calculations:

- You can’t evaluate clinical reasons for costs beyond the diagnosis.
- You can’t see co-morbidities that are not identified in patients with claims.
- Claims data on its own does not give you the story and tools your providers need to manage costs of care per patient. It

is a mishmash of services and charges that is codified for billing purposes and not cost-of-care management.
You won’t have longitudinal data on patients with changes in coverage, gaps in claims data availability by payer—which will include Medicare and Medicaid unless you are an ACO or other payment models that provide claims data. The more holes in your data, the more limited your approach to cost control.

Value-Based Care Strategies to Control Patient Care Costs

Value-Based Care focuses on data-driven improvements in outcomes and costs, replacing guesswork. Prior approaches to cost management required payers to question and deny services after-the-fact, or to mediate necessity of services through prior authorizations. That created a rat’s nest of trouble for payers, consumers, and providers.

Successful participation in value-based payment models involves data and technology to help clinicians improve outcomes, avoid complications and events for patients, and prevent problems before they occur. However, providers are still in the process of understanding and developing systems—as well as transforming clinician teams—to optimize care and costs.

The key strategies for implementing Value-Based Care strategies aimed at controlling patient care costs include these five

critical steps:

1. Organize your cost efforts by impact (patient volume and total cost) and by intervention type.

Your first task is to determine how to begin your effort. This is easy—go for your highest volume and highest cost areas. This is what the payers do, and it will matter most to your bottom line.

2. Develop your method for curating cost data.

How you will approach costs will require a specific approach to data aggregation. The reason some ACOs have achieved large savings is that they used data for particular projects. ACOs used claims data like HCC scores to assign patients to care management, admissions data to return patients to the office, diagnosis data to follow-up on patients with chronic disease, and provider data to renegotiate services for post-acute care. But overall savings have not reached high enough levels. Why? In segmenting costs, ACOs went after low-hanging fruit but failed to implement an overall approach, such as transforming clinical care of chronic disease or reducing specialty cost variation.

Among the best tools for reducing cost variation are procedural and treatment episodes of care, which require both claims and clinical data. Roji Episodes include both procedures and treatments, and call out inflections in cost. You can evaluate the reasons why costs were higher compared to others, and then work to effect solutions. Episodes of care are a tool to involve providers in improved care and costs. The transparent

case-oriented method is similar to training approaches for physicians and can be undertaken as a learning process.

Chronic disease episodes are also needed to manage the costs of a high-risk pool of patients. They are a means to avoid patient utilization and exacerbations. In Roji Episodes, cost avoidance is a primary goal, but it is accomplished by identifying patients at highest risk. The point is to predict patients whose outcomes are trending toward an event.

3. Aggregate and integrate claims and EHR data, along with financial data sources.

Recognize that worsening patient outcomes is a primary driver of costs, so obtaining detailed patient outcome data is essential. Patient comorbidities, historical hospitalizations and diagnoses, and medications are also needed. Financial data sources are critical to this aggregation. You will need to benchmark all episodes using a common fee schedule (e.g. Medicare) as well as actual claims for each payer. The cost investigation is not about payments; its purpose is to identify cost drivers. But when you do receive claims from payers, you need to understand their costs for successful negotiations.

4. Adopt Value-Based Care Technology.

Where does the data reside? It could be in your own repository. To be used effectively, however, the data must go into a Value-Based Care platform that siphons episodes into interventions and actions, by patient, within categories. Those might include clinical team review, or outreach, or change in clinical plan. You will most likely engage a Value-Based Vendor for the data aggregating, curating, and queuing these up for action.

5. Implement improvements and interventions.

There are limited possibilities for changing the trajectory of costs. Trimming specialty costs will involve collaborating with specialty groups and potential changes in referrals, but also a clear consensus on communication and clinical pathways for patients. During the next few years, we will see episodic payments expand and more global risk payment models that will then be subcontracted episodically to specialists.

Developing a short list of interventions for chronic disease and establishing a queue of patients for clinician or proceduralist review will be critical to the process. Clinical teams to support primary care physicians, as well as incorporating methods of carrying out large-scale improvements in chronic disease management and patient interventions will be essential to change.

If you've already begun looking at costs, you have a head start. But time is short. Contact Roji Health Intelligence for guidance and strategic insights.

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Image: Alex Shuper

Value-Based Care 2025: Providers Must Win the War on Costs

written by Theresa Hush | June 19, 2025

Health systems and ACOs: Prepare yourself for the return to cost containment as the central objective of Value-Based Care

in 2025. While cost measures have always been part of CMS Value-Based Care quality programs, their impact was small relative to the total MIPS score for physician groups. Likewise, ACO savings look big in dollars but comprise only a few percentage points of total Medicare spending. All that is about to change.

In short, cost-cutting is the new administration's top priority, and the track record on Value-Based Care cost control is not good enough to resist budget crunching. ACOs are the largest Value-Based Care program of the federal government, but they can't show proof of their impact on total Medicare spending due to program particulars. The Congressional Budget Office (CBO) projects a small increase—not decrease—in federal spending for Center for Medicare and Medicaid Innovation (CMMI) payment models from 2023-2033, even as it suggests that savings should subsequently accumulate.

The new administration ran on a platform that called for change, less government, and tax cuts. Improving access to care or health equity is no longer the focus.

Instead, 2025 will be the beginning of a shift to reduce Medicare and Medicaid spending, lower business costs of employee health care benefits, and turn savings into tax cuts for Americans. These won't necessarily be popular strategies with consumers or providers. In fact, a good number of people believe that more spending in Medicare is needed, according to a recent Kaiser Family Foundation tracking poll.

But time has run out for provider-led cost control. There are already administrative proposals on the table for cuts in

hospital reimbursements and a redefinition of reimbursement formulas, elimination of coverage under Medicaid expansion, and other levers to reduce payments to providers. If the issues are couched in terms of waste under the banner of Value-Based Care, support for cuts are inevitable. That’s why you need to be prepared to identify and eliminate any excess costs—starting now.

The most pressing question is whether cost containment will happen to your organization in the form of top-down cuts, or whether you will successfully adopt more rigorous and risk-based payment models. Convincing the administration that they can bank on these savings will be difficult. Even if you rejected value-based payments previously, your best hope is that such payment models will still be open to you, rather than the cuts already being proposed. You must be ready to demonstrate savings. Here is how you do it:

Step One: Arm Yourself to Reduce Costs

Unlike recent years, don’t count on a long glide path for the next phase of Value-Based Care. Start planning now with these tools:

1. Aggregated clinical data

If you’ve delayed aggregation of data from all your providers, correct course immediately. “All your providers” includes physician practices at both inpatient and outpatient facilities. If you have an ACO or Clinically Integrated Network

(CIN), or a Physician Hospital Organization (PHO), you have the vehicle to aggregate costs; if not, you will need to create the organization.

The data must be complete with significant clinical diagnoses and results of labs and diagnostic tests, therapies and procedures, medications, plus utilization and referral information. If you're wondering why you need all this data about your patients, understand that we are talking "Total Cost of Care" and "Per Patient Care Costs," both of which mean clinical costs. Your goal is to understand what is contributing to costs by type of care to find your opportunities for savings.

2. Claims data

To fill in the missing elements of care outside your network, you need claims data to show full costs. If your organization is participating in a CMS payment model that receives CMS claims, you'll gain a huge advantage by developing a full model to examine treatments and procedures. Negotiate with commercial carriers for this data, even though many providers have found it challenging to get.

3. Cost Technology for examining total cost of care and per patient costs

The most viable comparable analytics are clinically developed Episodes of Care. Roji Health Intelligence creates clinical Episodes of Care to show variation by procedures and to identify the drivers of higher (or lower) cost. Roji Episodes are also constructed for specific payment models, such as the Enhancing Oncology Model. Condition-based Roji Episodes

identify patients with higher risk or worsening outcomes. Clinical episodes create the trusted database you need to engage clinicians in cost control—assuming that you share the data with them in a way they can validate.

Step Two: Take Action

Reviewing and innovating change often arouses administrators' concerns about future revenues. You won't get derailed, however, if you can focus on efficiency and best practices in a collaborative process, using data. This should include:

1. Clinician Engagement in Cost

Physicians must see Episodes of Care data. They should be able to compare their outcomes and costs with others performing the same function or treating similar patients. They must be able to respond to identified cost issues within the cost technology.

2. Improvement Strategies and Interventions

Your cost technology should identify variances in care by screening for interventions in your standard of care for chronic disease. Procedural cost variations can be identified within each procedure type and by specialty. Potential interventions, such as a change in a clinical pathway or an individual treatment plan, should be part of the clinician review process.

The Consequences of Delay: Cost Containment Will Hit You and Your Patients Harder

Providers have made great leaps in adoption of EHRs, Value-Based Care strategies, and technologies over the past few years. While cost control has lagged, now is *not* the best time to let payers and government define the methods of cost control by reducing benefits or lowering provider rates. You can pivot to costs using investments you have already made in data, quality reporting, and alternative payment models.

To learn more about how to pivot to costs using Episodes in Care or quality reporting data, contact Roji Health Intelligence.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Sergey Kotenev

The 2025 CMS PFS Final Rule: The Five-Pronged Strategy Towards Comprehensive Accountable Care

written by Dave Halpert | June 19, 2025

The 2025 CMS PFS Rule landed with a bang, and it's not just the weight of the 3,088 pages.

We're one year closer to 2030, the year that CMS intends to have all Traditional Medicare patients in a relationship with a clinician who is accountable for total cost of care. The push to the finish line is the primary driver behind each of the QPP-related policies in this Rule. For CMS to accomplish its goal within its stated time-frame, accountable care programs must promote equity, expand into rural and underserved areas, and align to reduce administrative burden.

A slew of new rules will take effect in just two short months, and those who aren't familiar with the changes and the reasoning behind them will find themselves fighting to keep afloat as these updates and downstream consequences are felt. Here are the five key policies you need to understand, as they can determine whether your value-based care journey brings

payments or penalties.

1. Rewarding High-Performing ACOs with Prepaid Shared Savings

To address ongoing maintenance costs and facilitate continuous improvement, CMS has approved its Prepaid Shared Savings proposal. ACOs who have a track record of earning shared savings, and who are in a two-sided model (BASIC C-E or ENHANCED tracks), have the opportunity to receive an advance on potential shared savings and reinvest them in the ACO and its patients. At least half of these Prepaid Shared Savings must go to direct beneficiary services that aren't already paid by CMS, and, of course, they must be evidence-based and appropriate, depending on the individual beneficiary's clinical and social risk factors.

The remaining Prepaid Shared Savings may be spent on staffing and, importantly, on investments to health care infrastructure. This gives you the opportunity to partner with a data analytics and aggregation vendor who will identify your pain points and give you the tools to address them.

Prepaid Shared Savings fall into CMS's larger strategy of prioritizing primary care through other programs like ACO PC FLEX and the Making Care Primary (MCP) Model. In addition to program-specific guidance, the Accountable Care coverage umbrella will be further extended through the introduction of Advanced Primary Care Management (APCM) services. The purpose is to facilitate the delivery of advanced primary care, particularly as APCM services relate to managing principal care, transitions, and chronic conditions. These are intended to pay for primary care in a hybrid model (i.e. population-

based payments and payments for encounters), rather than strictly Fee for Service.

2. Incentives for ACOs in Rural and Underserved Communities

In order to ensure that all Traditional Medicare beneficiaries are in an accountable care relationship, support for ACOs in rural and underserved areas is critical. To entice providers in these areas, CMS has finalized its proposed Health Equity Benchmark Adjustment (HEBA).

The HEBA is calculated based on the proportion of beneficiaries who are enrolled in the Medicare Part D Low Income Subsidy (LIS) or who are dually eligible for Medicaid and Medicare. The HEBA will be a third method for increasing an ACO's historical benchmark.

In other words, an ACO will be able to spend more on patient care before crossing from shared savings into shared losses. The HEBA will also offset the Congressional Budget Office finding that ACOs launching in rural and underserved communities have higher start-up costs than their peers. Furthermore, this will help to mitigate the historically (and unfortunately) low health care spending trends in rural and underserved communities.

3. Termination Protections for Small ACOs

For small ACOs in rural and underserved areas, CMS is adding an element of stability through updates to its policy regarding minimum beneficiary count. Currently, an ACO must have at least 5,000 assigned beneficiaries by the end of the performance

year, and those who don’t must create and fulfill a Corrective Action Plan (CAP) to bring that number up—or face automatic termination. There were 24 ACOs between 2020 and 2023 that were affected by this policy. After CMS enforced the existing requirements, more than half of those ACOs chose to voluntarily terminate ahead of their Corrective Action Plan (CAP) deadline, taking patients out of accountable care relationships, rather than putting them in.

Here’s the problem: the fewer the beneficiaries, the less reliable the calculations for Minimum Savings Rate (MSR) and Minimum Loss Rate (MLR). In other words, without a sufficient sample of beneficiaries, there isn’t a reliable way to measure whether the ACO is reducing spending and improving quality.

However, in recent years, CMS has been able to calculate MSR and MLR on a sliding scale, based on the number of beneficiaries within the ACO. CMS says that this has proven to be an effective guardrail against making overpayments and underpayments, and it is reliable enough to inform whether to reconsider actions taken when an ACO’s beneficiary count falls below 5,000. Rather than an automatic termination following the end of the CAP, CMS may take a more flexible approach, which facilitates CMS’s goal of increasing the number of existing ACOs and their beneficiaries.

4. Shaking Up ACO Quality Reporting (Again)

In the Proposed Rule, CMS outlined its plans to align quality reporting requirements in its programs using the Universal Foundation of Measures.

They’ve codified that process here, creating an APP Plus

Measure Set (APP Plus), which will expand each year, beginning in 2025 with a fourth measure: Breast Cancer Screening. The expansion of the APP Plus measure set may seem daunting, but those who utilize the additional information to help control patient care costs will reap additional benefits. The APP Plus measures will all be reportable through Medicare CQMs, eCQMs, *and* . . . MIPS CQMs.

Yes, CMS has walked back from its proposal to eliminate the MIPS CQM reporting option in the APP Plus, as many ACOs have already developed or contracted with entities to report MIPS CQMs. We are thrilled with this decision; as we described, the QRDA files behind eCQM reporting have limited value and are often unreliable, as they do not account for variations in documentation that can occur between providers (even if they're in the same office!).

The MIPS CQM collection type has been granted a reprieve for 2025 and 2026, which will enable ACOs to gain more experience in all-payer reporting, and to do so when the APP Plus Measure Set is smaller than its eventual iteration. MIPS CQMs will also be folded back into the all-patient reporting incentive, wherein an ACO can meet the Quality Standard (earn shared savings) under a more lenient scoring methodology.

Although CMS has temporarily brought MIPS CQMs back into play, they make no secret that they've pinned their future quality reporting requirements on eCQMs, and are incentivizing their use through a Complex Organization Bonus, adding points for measures submitted as eCQMs.

Although eCQMs are not currently optimized for Digital Quality

Measures (dQMs), CMS believes the Fast Healthcare Interoperable Resource (FHIR) standard will gain widespread use over the next five years, facilitating that transition. Interestingly, although CMS cites a 5-year estimate for FHIR adoption, the MIPS CQM option is only granted a two-year extension.

The third reporting option, Medicare CQMs, receive treatment in the Rule, as well. Since these measures have only been scored using the Web Interface and all-patient submissions, there was a question about how they would be benchmarked when reported for all eligible attributed ACO patients. Until a reliable benchmark is created, Medicare CQMs will be scored using "flat" benchmarks (i.e. 10 points for performance greater than 90 percent, 9 points for performance between 80 and 89.99, etc.) so that ACOs with the ability to aggregate data from their disparate EHRs can reliably estimate performance and identify areas for improvement.

5. MVPs: The Ulterior Motive Behind Favorable MIPS Policies

There are fewer shake-ups on the MIPS side of the QPP house; the major proposals from this summer have all been finalized. The result is that MIPS retains an element of stability. But don't be lulled into complacency—the reasoning behind this consistency (for now) is to offer a firm jumping-off point for providers and organizations to transition to MVPs or Advanced Alternate Payment Models (APMs), including ACOs.

In the short-term, though, MIPS participants can breathe a sigh of relief that the minimum performance threshold for MIPS remains at 75 points, rather than the anticipated 82 that was floated last year. The data completion threshold for quality

measures is also frozen at 75 percent, all the way through the 2028 performance period. As an added bonus, Improvement Activities are shifting from a weighted, point-based approach to a simple count—those who complete two Improvement Activities will earn full Improvement Activity credit. Promoting Interoperability requirements are also unchanged.

That leaves the Cost component. Cost has hit MIPS participants especially hard; with the category being re-weighted in prior years, providers did not have a good feel for how they would score, or what they needed to do to improve. Once Cost was rolled into the MIPS score, providers saw it to be the biggest obstacle to clearing the Minimum Performance Threshold, and also the most opaque. With Cost accounting for 30 percent of the MIPS score, even perfect performance in the other three categories cannot guarantee protection against penalties. Using the existing scoring standard, that is not as hyperbolic as it sounds.

By approving the proposed scoring updates for Cost measures, CMS has eased those pains. Rather than the existing performance benchmark policy, the new methodology is tied to the median (50th percentile) score and standard deviations. The result is that providers who score in the middle of the pack are not disproportionately punished and pulled below the Minimum Performance Threshold. As an added bonus, CMS is implementing this policy beginning with the current (2024) performance period, as scores will not be calculated until 2025, and therefore, can be codified in the 2025 Rule.

As good as this sounds, it is not a permanent reprieve. As groups ramp up their efforts to understand the reasons for

variations and begin to make improvements, those who don't will see the low Cost scores that plagued them before.

To increase MVP participation among specialists, certain (but not all) topped-out measures will have their 7-point caps removed so that specialty providers can report on clinically relevant measures without seeing their quality scores artificially cut down. The hope is that this will remove a barrier to specialists participating in MVPs so that consumers can make meaningful comparisons using CMS's public reporting tools. This would correct an existing issue in which specialists, especially those in multi-specialty groups, can skate by on the Quality component of MIPS by reporting measures that do not accurately measure quality of care.

With the quality measures addressed, CMS can move onto the next barrier it faces when creating specialty-centric MVPs: identifying cost measures that are directly attributable to a specific clinician. For that reason, there will be continued development of new cost measures, which will be utilized in both Traditional MIPS and an applicable MVP. The 2025 performance year is no exception, and six new episodic cost measures are being rolled out. Of these, five are chronic condition-based, and will be triggered with 20 eligible cases. The remaining measure is a procedural measure, and only requires 10 eligible cases for automatic scoring. For 2025, that brings the total to 33 episode-based cost measures and two population-based cost measures.

Although there is a lot in this Rule that supports MIPS participation, ongoing program maintenance leads to uncertainty. For example, a whopping 66 measures have received

substantive changes, which makes predictions difficult and could impact existing workflows. Two of them have an even greater impact, as they are both in the APP Plus measure set. Once measure specifications are released (before the start of the performance period is all we know!), organizations should study these (and all other changes within this Rule) carefully to avoid pitfalls.

Founded in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk.

Image: Birger Strahl

Your ACO May Already Be Late for APP Reporting. Here’s How to Catch Up!

written by Theresa Hush | June 19, 2025

With one year remaining before mandatory APP Reporting in 2026, the idea that you're already late may sound exaggerated. But consider the significance of what you're undertaking: This is your first effort to report quality on *all* your beneficiaries, not just a tiny sliver of patients. It's a huge leap that requires a lot of advance work. Throughout the 2025 Performance Year data for reporting in 2026, you will be accumulating measure data—or not. You have no chance to improve your quality metrics once 2025 is closed.

For your ACO to be ready for APP Reporting in 2026, you must make and implement numerous decisions and strategies, starting with aggregation of data. These require a series of steps, then tests, to put you at the starting line.

Let’s see if your ACO is running late. Here are the signs that you are not well-positioned for APP Reporting and still have a lot to do:

> You’ve been waiting for the Final Rule to prove that you must change from the Web Interface method of reporting (which you *can* use for 2025 reporting on Performance Year 2024).
> You’re still confused about what you need to do for APP Reporting.
> You don’t have an APP Reporting vendor.
> You haven’t decided on your best method for APP Reporting.
> You don’t have information on your participating practice EHRs.
> You haven’t collected any data.

Roji TIPS Are Here to Help Your ACO Ramp Up for APP Reporting

If you’ve been avoiding APP Reporting throughout 2024, you need a latecomer’s ACO strategy for PY 2025 APP Reporting in 2026. We are launching a series of concise Roji TIPS to address issues and questions specific to APP Reporting, beginning with *How to Untangle the Optimal Method for APP Reporting*. You can download free TIPS here.

Our goal is to educate, share our insights into the pros and cons of different approaches, and make your decisions easier—particularly given the tight time frame.

Especially if you are new to data and data-driven strategies,

we will be integrating approaches to position your ACO for data sufficiency for quality reporting and more.

Our focus will be on resolving the obstacles standing in your way to APP Reporting. Roji TIPS will help you understand the basic (and evolving) requirements around data aggregation. For example, CMS recently clarified that even Medicare CQMs in APP Reporting will require validation of the patients eligible for the measure, such as the aggregation of data from billing and practice management systems or EHRs. Prior to this, most in the industry assumed that the CMS patient eligibility lists would suffice for the denominator of measures. No longer.

We'll also demystify the selection of reporting method, which will include either eCQMs or MIPS CQMs for all patients, or Medicare CQMs for Medicare beneficiaries only. The Final Rule re-establishes MIPS CQMs for APP Reporting for PY 2025 and 2026.

There's no need to panic or avoid what's coming. In fact, we see positive outcomes for ACOs that are early adopters of APP Reporting. Remember what's essential in today's highly competitive health care environment: You must understand your patient data and how it can enable you to improve your ACO strategies for population health, cost management, health equity, and measuring and reporting quality.

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Image: Andy Beales