

Reading the Future of Medicare Value-Based Care in CMS Payment Models

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Why Trust Roji Health Intelligence on Payment Models?

We enable providers to thrive under risk-based payment

Roji Episode Analytics enable you to measure and deliver better outcomes while managing costs

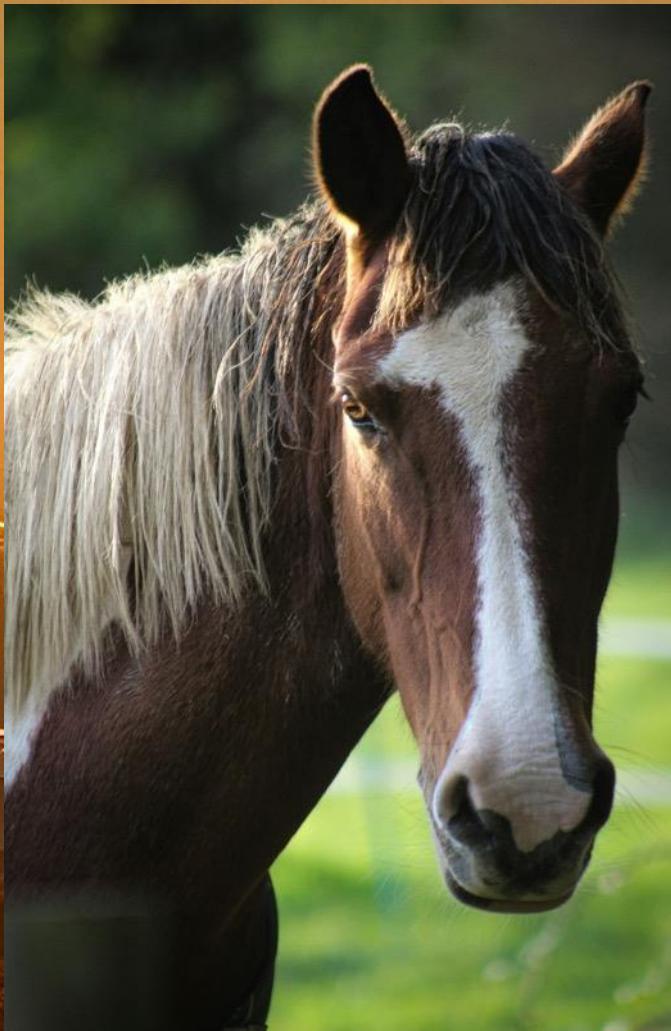
Dedicated payment model services for ACOs, TEAM, ASM, EOM, Kidney Care

Roji is a Qualified Registry for MIPS, MVP, and APP Reporting

Where does your organization sit with CMS Payment Models?



A. We're watching and waiting.

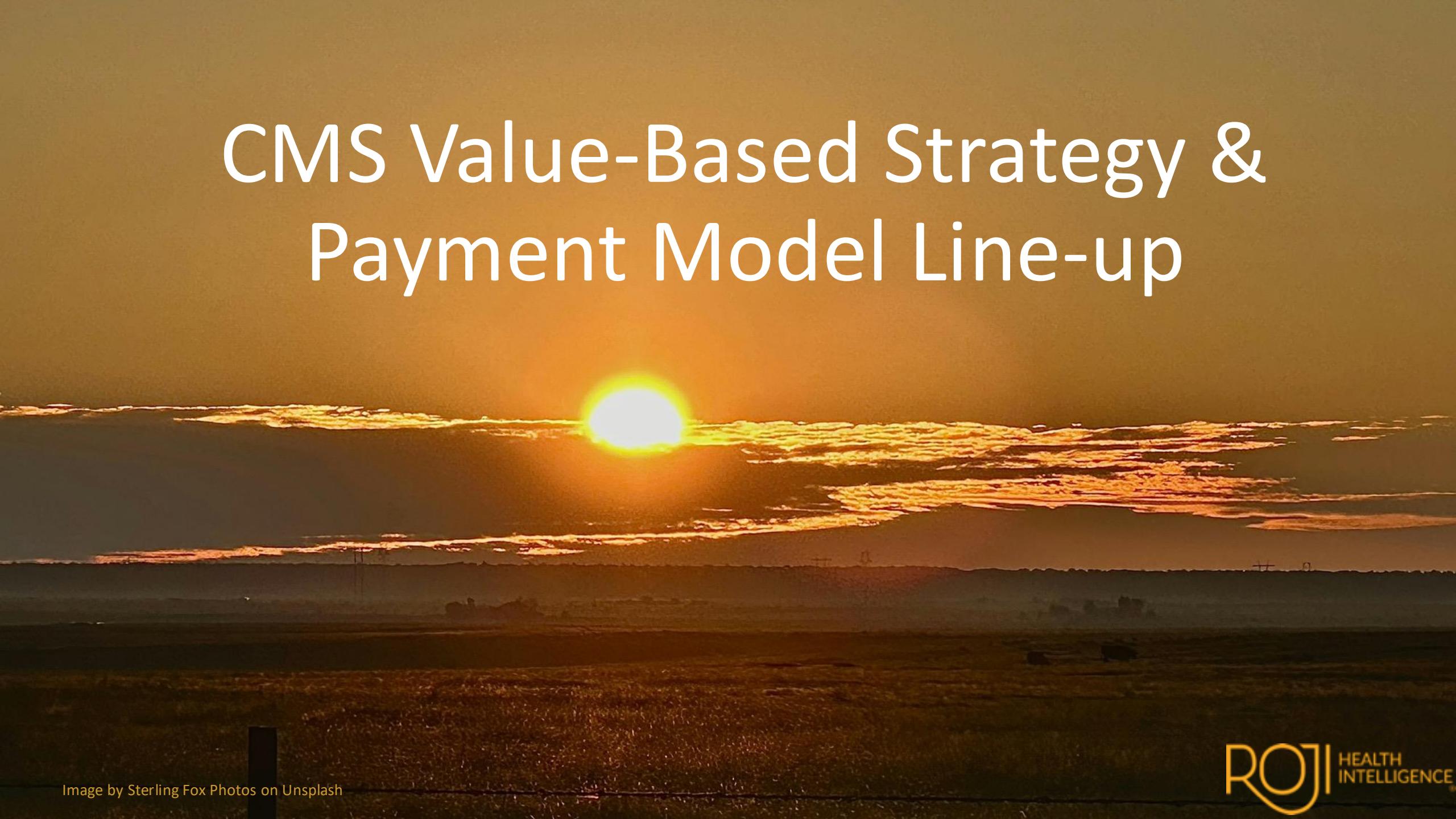


B. We have limited risk-payment models.



C. We're already in risk-based models & ready to expand.

CMS Value-Based Strategy & Payment Model Line-up



Role of Payment Models in CMS VBC Strategy

In Past Years

- Test how payments influence cost, quality
- Expand primary care resources
- Improve incentives for value & savings
- Improve equity of health care
- Reduce spending in Medicare program

Now

- Change reimbursement method
- Develop fixed rate payments for high-risk/expense populations
- Use risk models to engage providers in value
- Improve coordination of specialty care
- Reduce specialty costs
- Fixed fees for Medicare

CMS Payment Model Line-up to Kick Off 2026

ACO (MSSP) – Accountable Care Organization (Shared Savings)

ACCESS – Advancing Chronic Care with Effective, Scalable Solutions

EOM - Enhanced Oncology Model

Kidney Care Choices

TEAM – Transforming Episode Accountability Model

ASM – Ambulatory Specialty Model

MEDICARE ADVANTAGE PLANS

CMS Payment Models We Won't Cover Today

LEAD – To Replace ACO REACH in 2027 with a rural-focused model, with model features not fully developed yet.

ACO REACH – To expire at end of 2026.

ACO PC FLEX – We will cover features within ACO MSSP model

AHEAD – State-focused program

Common Features of Payment Models:

Keep an eye on

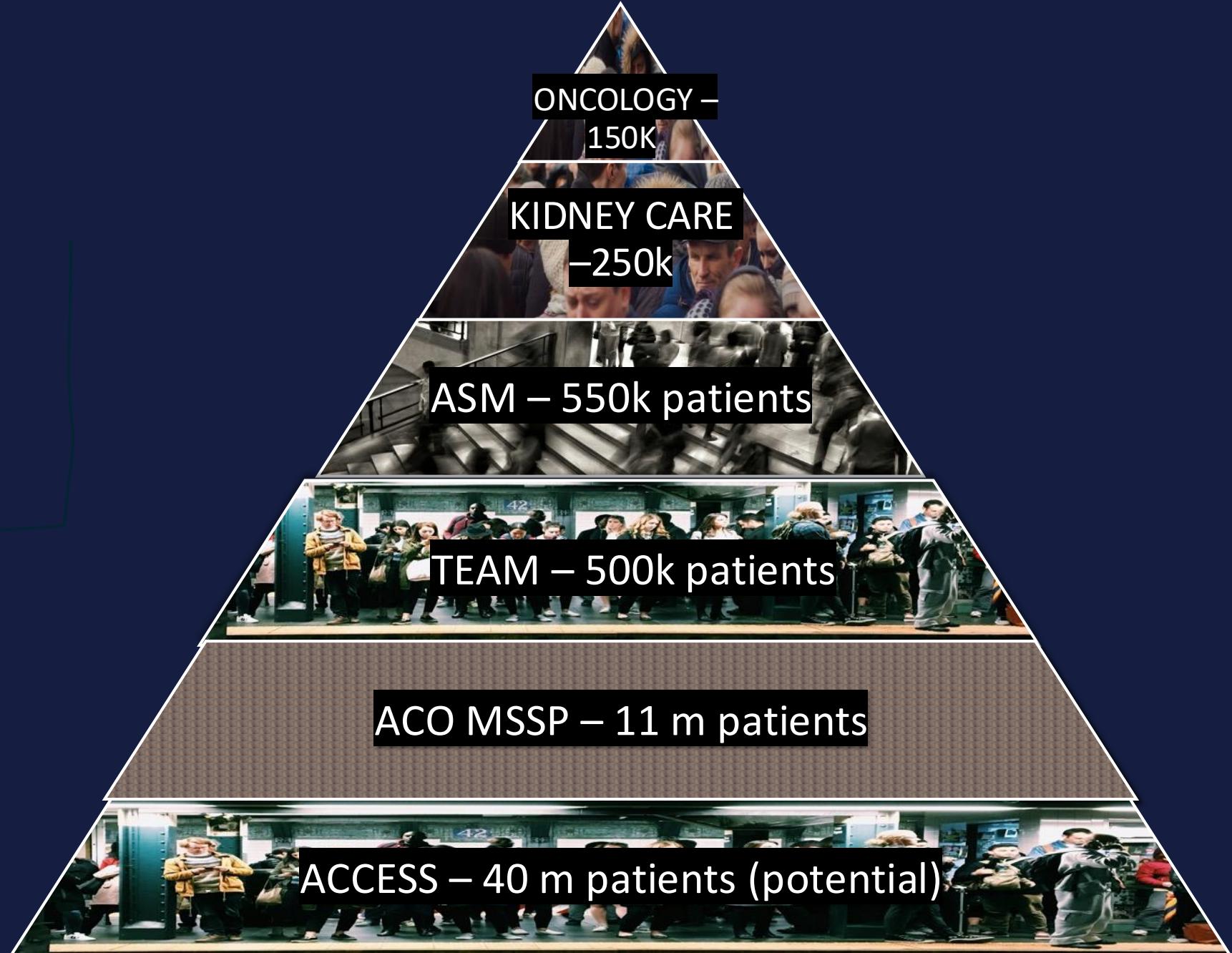
- scope & size
- how the money flows
- cost & quality measures
- reconciliation finance



Payment Model Breakdown

Model	Participants	Focus Area
Enhancing Oncology Model (EOM)	34 practices, multiple sites	Episodic costs of chemotherapy (~21,300 in first 6 months)
Kidney Care Choices (KCC) Model	93 practices and contracting entities	Kidney care costs (~430,000 receiving hemodialysis)
Shared Savings Program ACO	480 ACOs, 643,000 clinicians	Total cost of care for ~10.8 million patients
Transforming Episode Accountability Model (TEAM)	745 hospitals	Episodic costs associated with 5 types of procedures
Ambulatory Specialty Model (ASM)	To be determined	Condition-specific cost of care (back pain and heart failure)
Advancing Chronic Care with Effective Scalable Solutions (ACCESS) Model	To be determined	Condition-specific outcomes for (potentially) 40 million patients

Scope & Size of Payment Models



How Risk Features in Each Payment Model

ACCESS: Outcome aligned payments for Enrolled Patients

TEAM: Hospital risk; 10% Cap – Can share gains/ losses with Collaborators

ACO MSSP: Glide Path to downside Risk, Capped at 8% for practitioners

ASM: Practitioner risk; 10% Cap – Can share gains/ losses with Collaborators

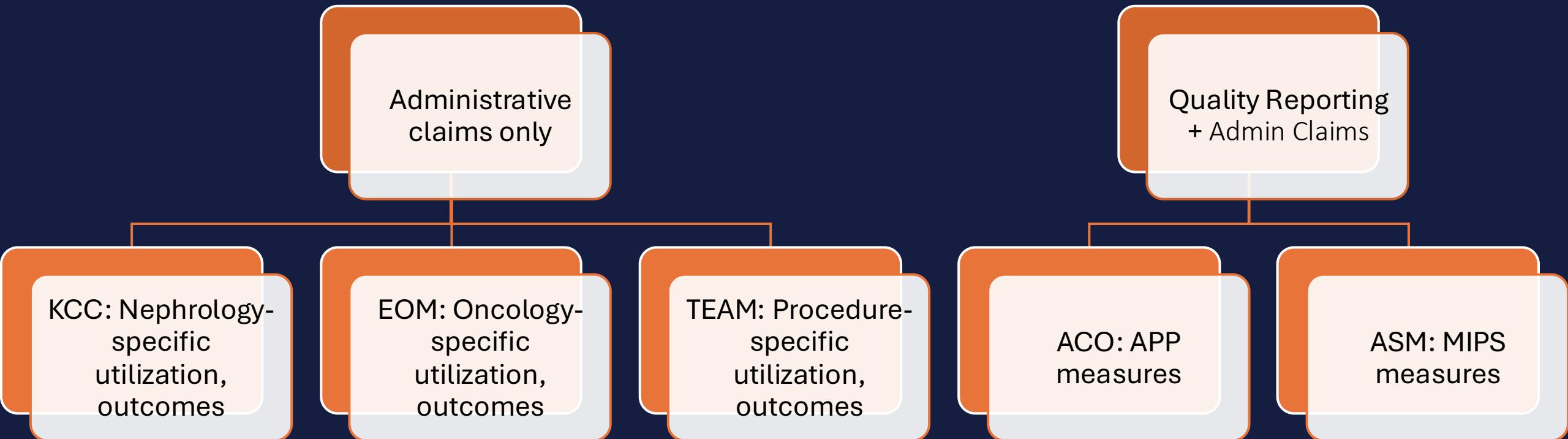
Enhancing Oncology: Practitioner Risk – Qtrly Reconciliation of Costs to Target

Risk is Heating Up

- Mandatory models make risk a non-negotiable feature in recent models, vs. ACOs
- Level of risk is higher
- Who's at risk is expanding to more provider types



Quality Measures



Cost Measures

Kidney Care Choices

Enhanced Oncology

TEAM

ACO MSSP

ASM

Total Cost of Care for CKD, ESRD

TCC Chemo costs

Total Surgical Episode Cost

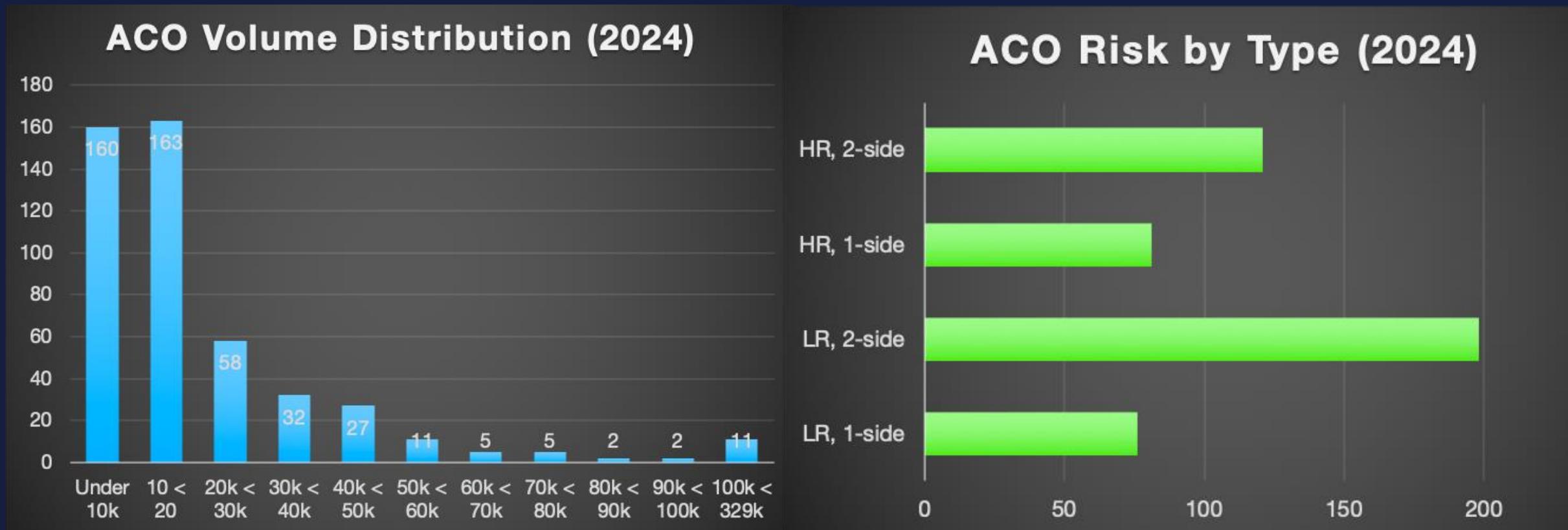
Total Cost of Care algorithm

Total treatment Treatment Episode Cost

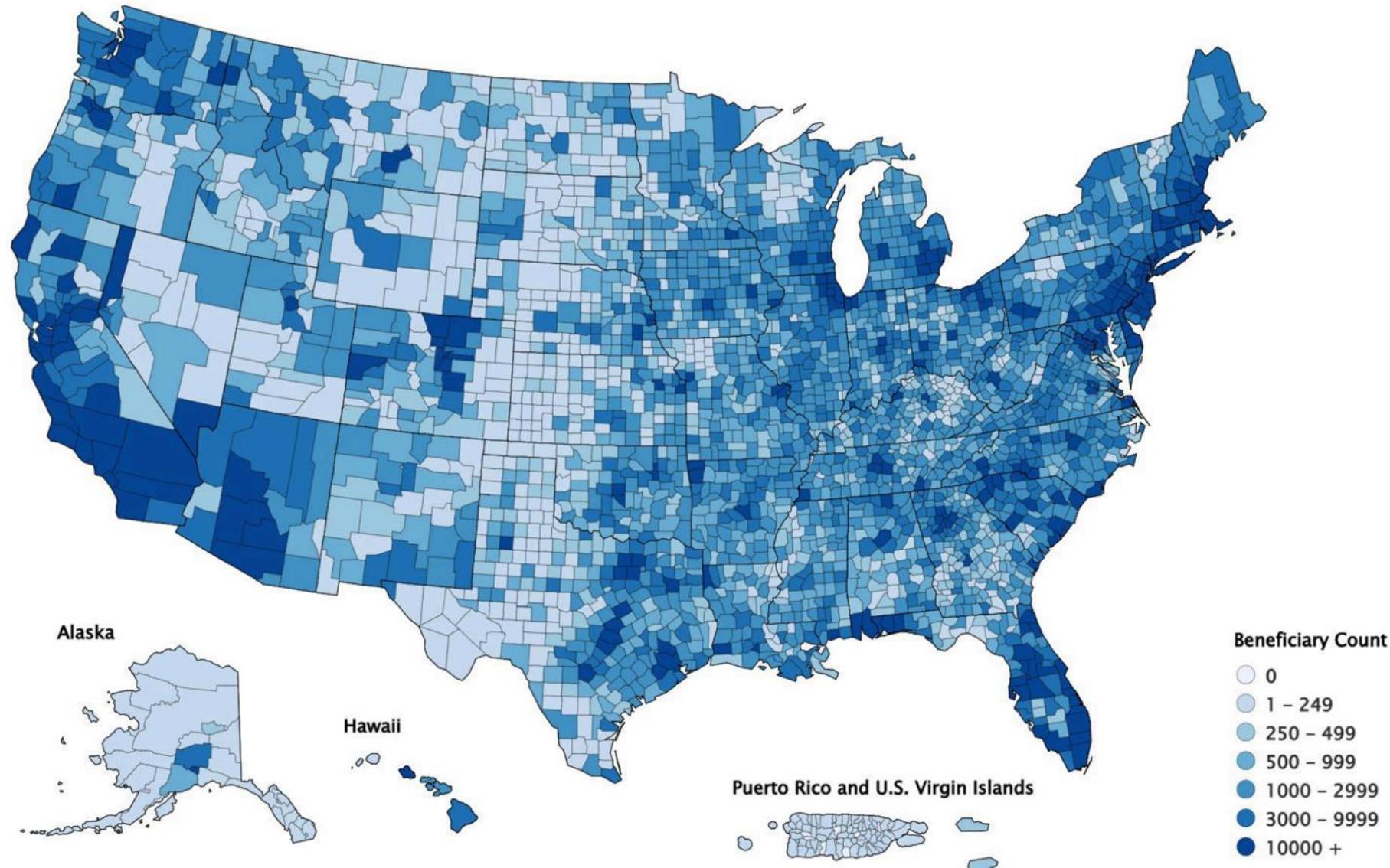


Hey, have you noticed how many of these Models are about Total Cost of Care?

The Current ACO Landscape



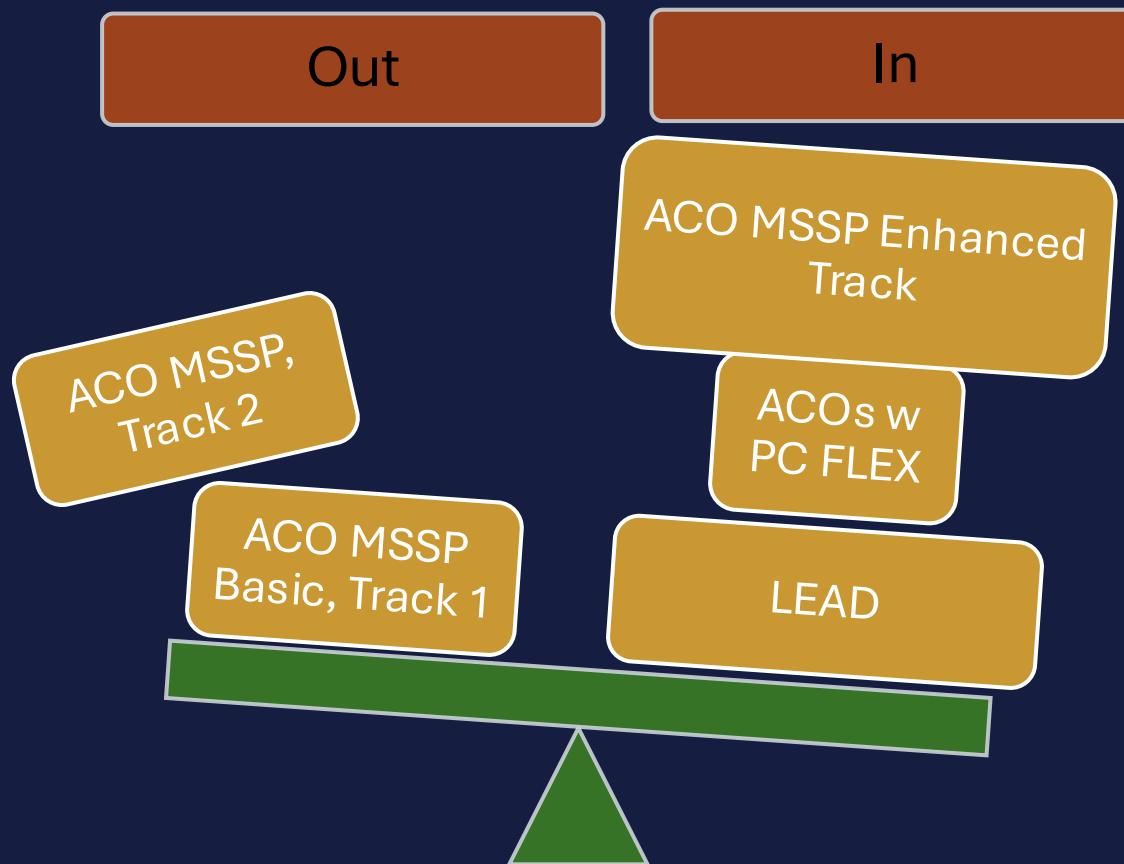
Medicare Shared Savings Program ACO Assigned Beneficiary Population by County



ACO MSSP Model Development Path



ACO MSSPs: Re-envisioned and Rearranged





The Future of ACOs

- Savings expand participation options
 - LEAD (Long-term Enhanced ACO Design)
 - Potential higher-risk MSSP Track
 - Constricted one-sided risk periods
- Voluntary models must entice
 - Prospective payments
 - Predictable benchmarks
 - Support for high-needs patients
 - Beneficiary engagements
- Risk Arrangement Agreements

How CMS is Using Accountability to Improve Value (and How it Will Evolve)



Individual Primary Care Accountability: Advance Primary Care Management Services (APCMs)



APC = Principal/Transitional/Chronic condition care management



A monthly bundled payment covering "advanced primary care" services



Can be billed by independent providers or providers within an ACO



Stringent, comprehensive requirements if using (e.g. consent with cost-sharing warning, access, care plan, communication)



Do not exclude from quality reporting (APP or Primary Care MVP) or potential penalties for excess cost

Advancing Chronic Care with Effective Scalable Solutions (ACCESS) Model

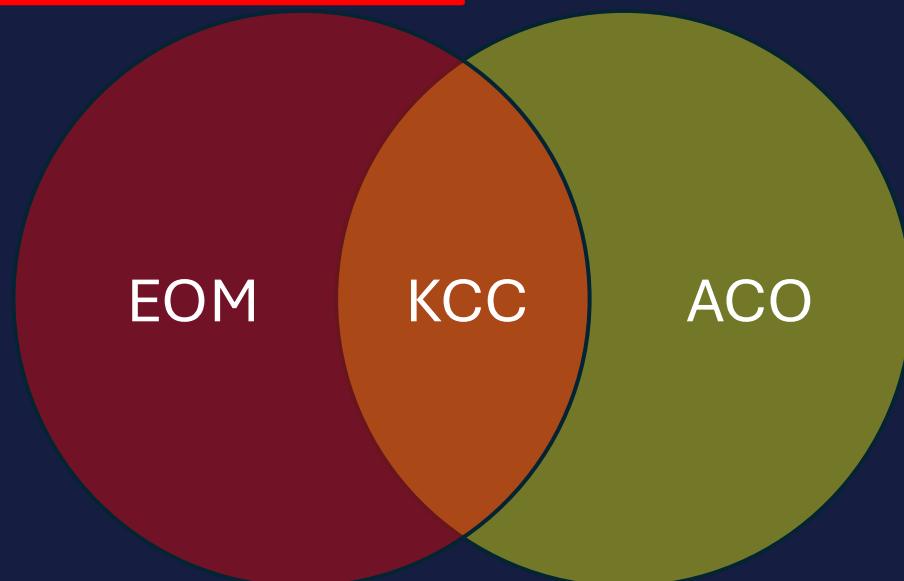
- Recurrent payments for condition management
- Contingent on outcomes, not savings
- Must incorporate HIPAA-compliant data sharing
- Allows use of pt-focused digital health tech
- Clinical Tracks
 - Early Cardio-Kidney-Metabolic (e.g. HTN)
 - Cardio-Kidney-Metabolic (e.g. Diabetes, CKD)
 - Musculoskeletal (e.g. chronic pain)
 - Behavioral Health (e.g. depression, anxiety)



Specialty Care Payment



Specialty-Based



Multiple Tracks



Future of Specialty Models

- Expansion of specialty care procedures and treatment Dx
- Involuntary vs voluntary
- Involvement of ACOs in primary care
- Potentially more intrusion in care plans
- Required patient education, decisions
- Required price transparency
- Results will be public



Hidden Reflections of Payment Models

ROI
HEALTH
INTELLIGENCE

MIPS Cost Measures = APM Training Wheels

- Merit-Based Payment System (MIPS): Alternate path to APMs
 - Scoring determines positive or negative payment adjustment
 - 30% of MIPS Score derived from Cost
 - Utilization metrics also contribute to final score
- 35 Cost measures (33 specific, 2 population-based)
 - Procedural, chronic- and acute-condition Episode-Based Cost Measures (EBCMs)
 - Goal: Enable "apples-to-apples" value-based comparisons
 - No opt-in or selection; CMS determines eligibility, adjustment, and score



MVPs and Future Models

- "MIPS 2.0": MIPS Value Pathways (MVPs)
 - Specialty-based participation
 - Limited quality and cost measures
 - Will be mandatory for non-APM clinicians
- Framework for ASM; more will follow
 - MVP candidates signal gaps and priorities (diabetes, hypertension, critical care)
 - Tested cost measures affirm validity, promote consistency for future models



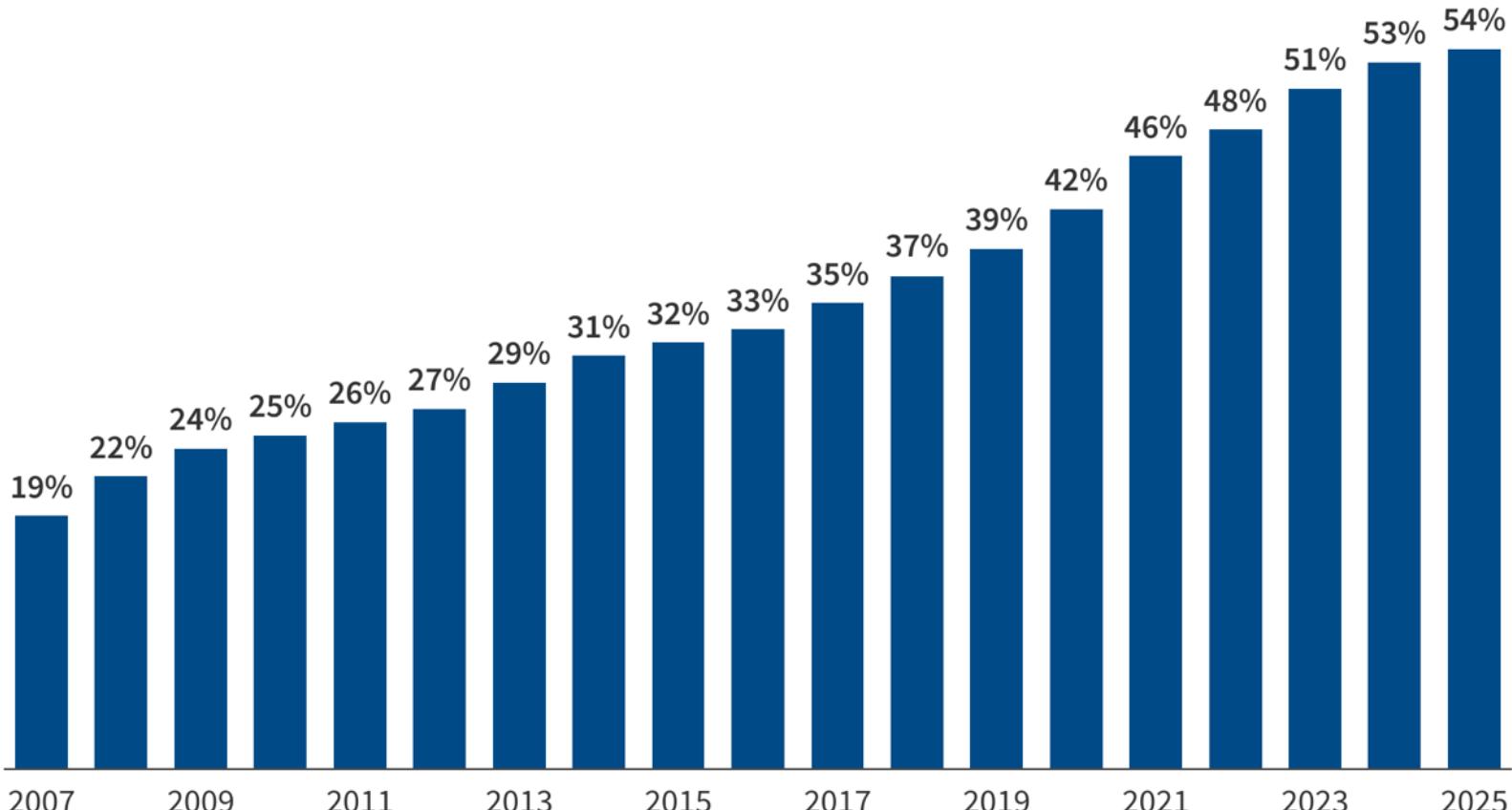
Medicare Advantage:

Despite its perceived flaws, MA is by far the biggest payment model in Medicare, at over 62.8 m beneficiaries enrolled.

Medicare Advantage > 50%

Figure 1

Total Medicare Advantage Enrollment, 2007-2025



Note: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 62.8 million people are enrolled in Medicare Parts A and B in 2025.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2025; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; CCW data from 100 percent of beneficiaries, 2021-2023, and Medicare Enrollment Dashboard 2024-2025.

Where Is MA Going, Besides Up?

- Attempts to moderate harm from Prior Auths
- Risk Adjustments have helped boost Plan revenues
- Neutralize the risk coding advancements that Plans have made
- Strong push to privatize Medicare, but does MA want higher risk patients?



How Providers Can Create the Future They Want



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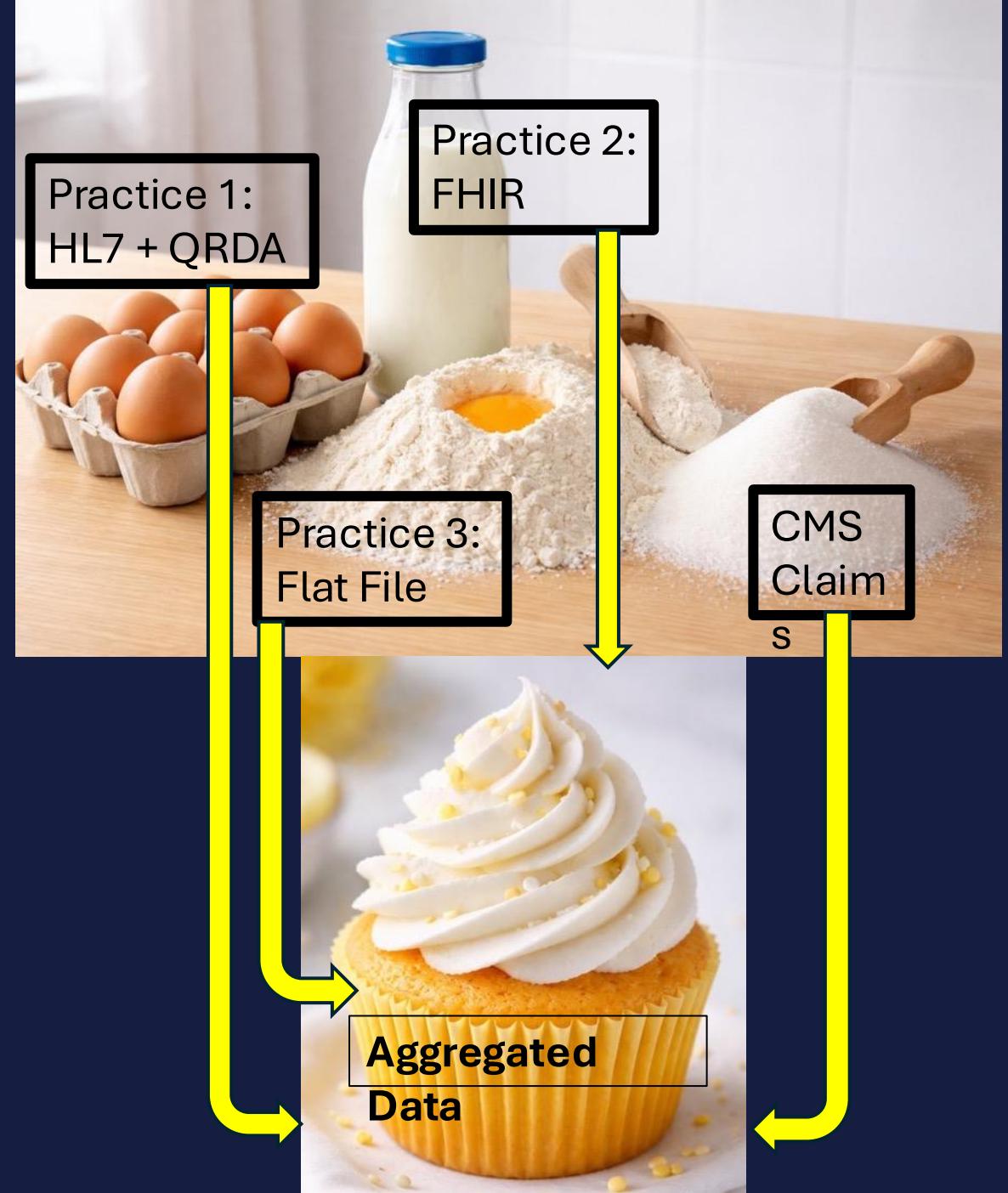
Pillars of your VBC Savings Strategy

- Hospital-provider collaboration
- Meaningful quality and cost feedback
- Patient-centered care
- Single (high) standard of care
- Recognize and address HRSNs



Data Aggregation

- Disparate data sources (hospitals and practices)
- Can include CMS claims
- Full aggregation necessary – QRDA are insufficient
- Background legwork is critical – surprises equal delays
- Must-knows: ONC status, export capabilities, contacts



Provider Collaboration

- A relationship where the goal is improvement and Data > Reputation
- Recognition that data aggregation is necessary, but not sufficient
- Engagement from leadership and Clinical Data Registry
- One or more provider champions to educate and inspire

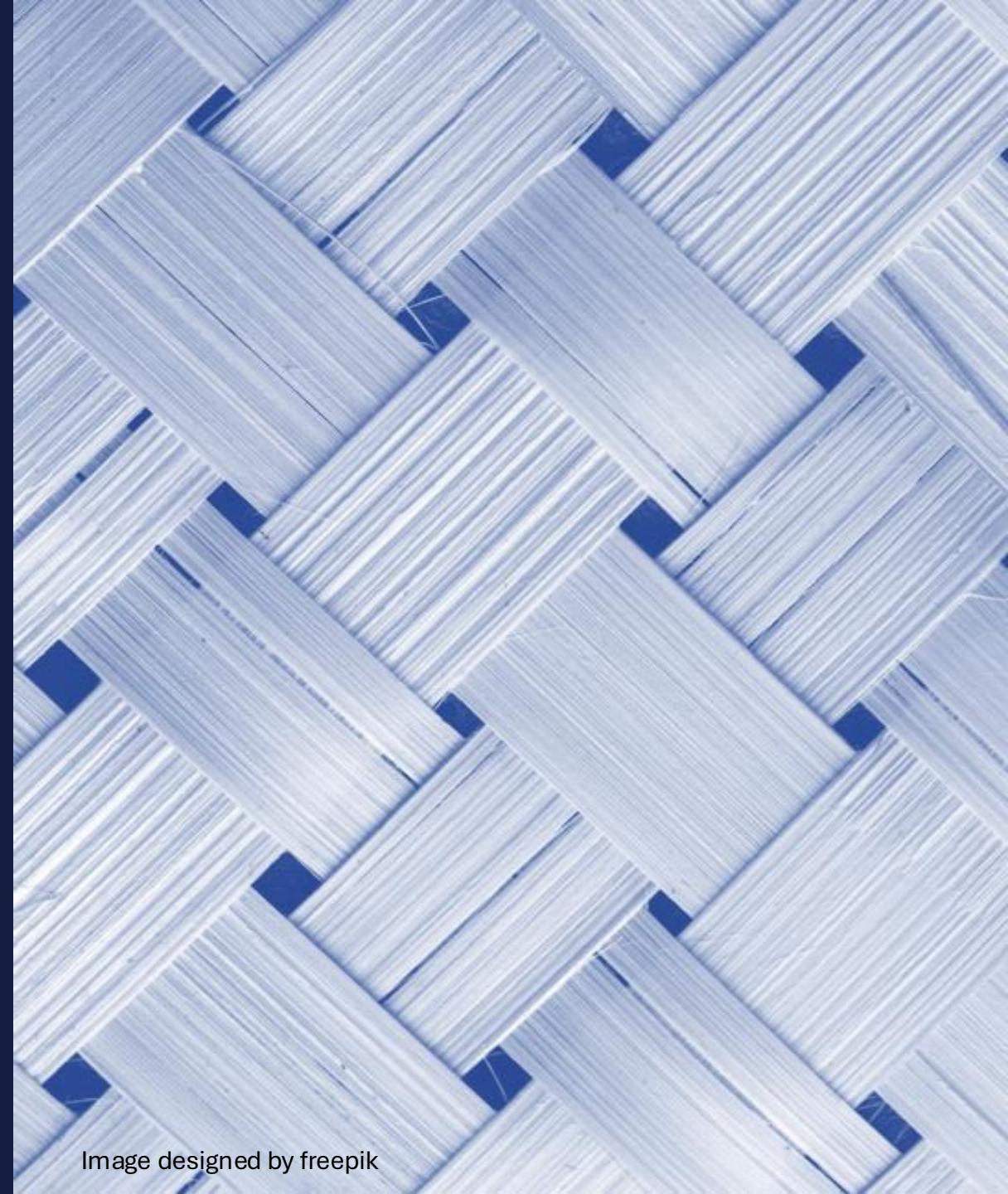


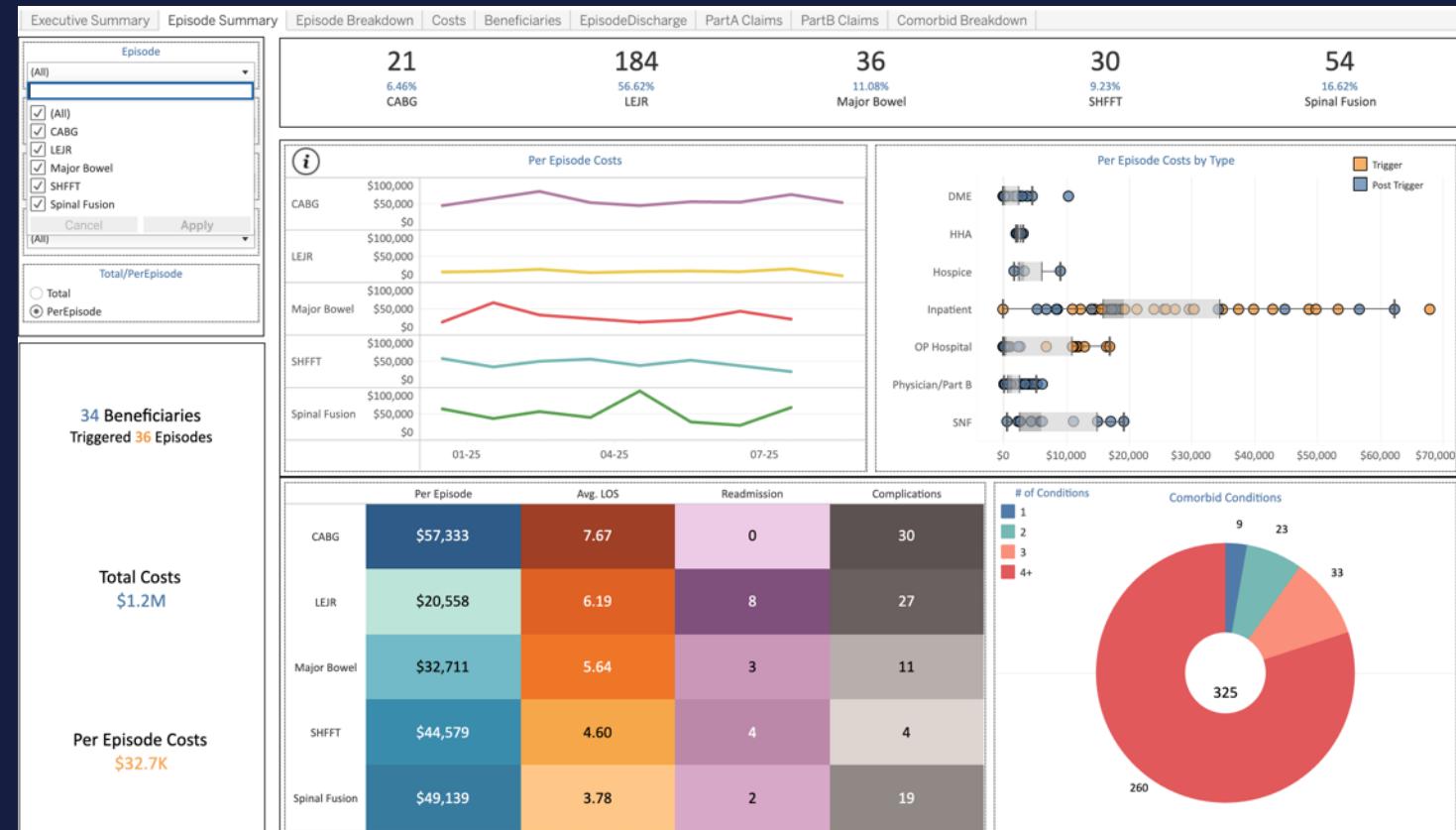
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Provider Responsibilities

- Maintain a collegial learning environment
- Accountability requires root cause analysis
 - What led to a complication?
 - Why was a specific drug utilized?
- Address systemic issues with hospitals
 - Procedures: Surgical protocols (incl. anesthesia decisions) and settings, infection control, blood management
 - Conditions: Hospital admission guidelines, diagnostics, discharge instructions

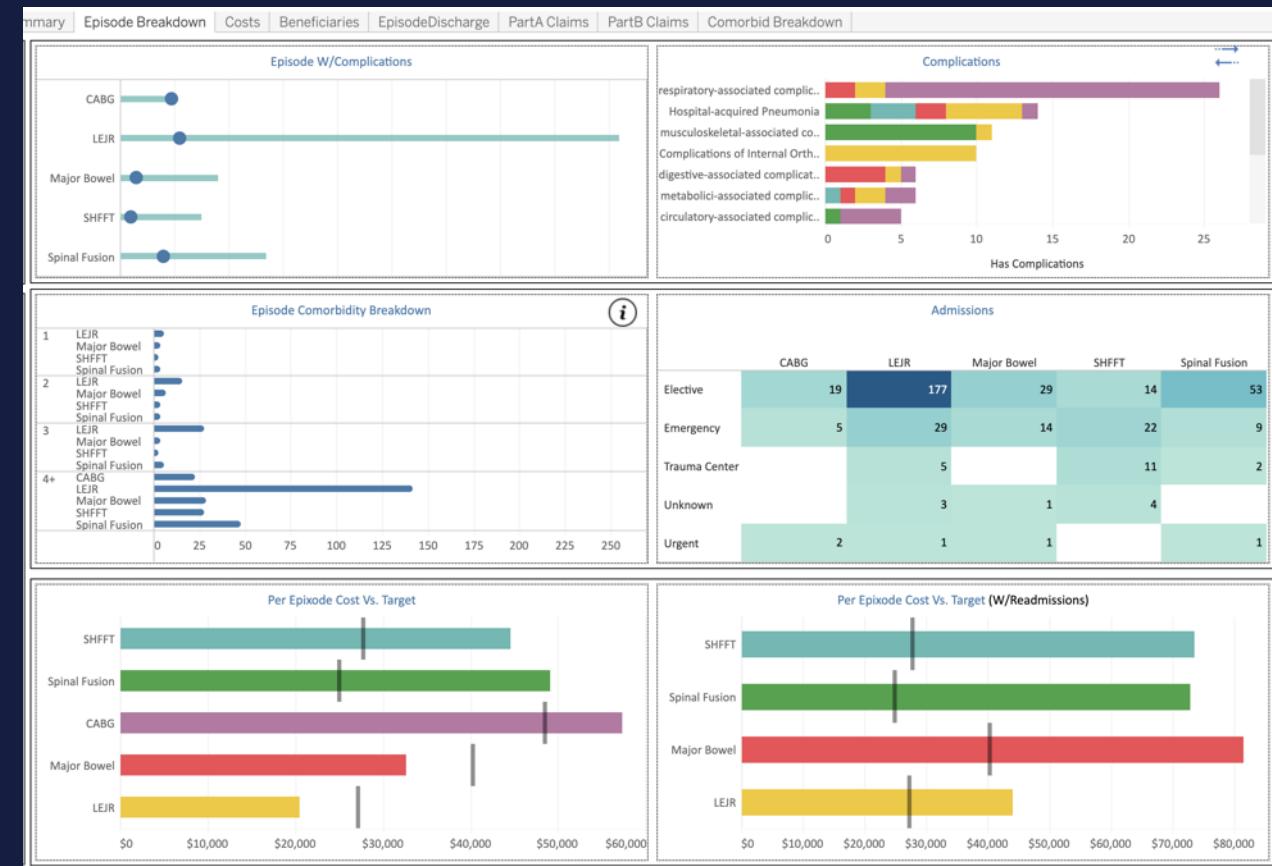
Are You Ready for Specialty Payment Models?

- Participants need their own analytics / episodes to see cost variation, differentiate main causes
- Aggregated data turns fragmented services into 360° episodes
- Incorporate EHR and claims for patient risk, complications
- Ongoing data refreshes reveal efficacy of interventions



Roji has ACO and Specialty Model Platforms for Episodes and Analytics - Customized to your plan

- TEAM, EOM, and KCC are active; ASM (2027) slated for mid-2026 release
- Don't start from scratch! Before beginning, know:
 - Over the last 2 years, the top 5 cost drivers per clinical area
 - Provider, practice, site comparisons
 - Explanations for cost variation (e.g. approach, facility, patients)



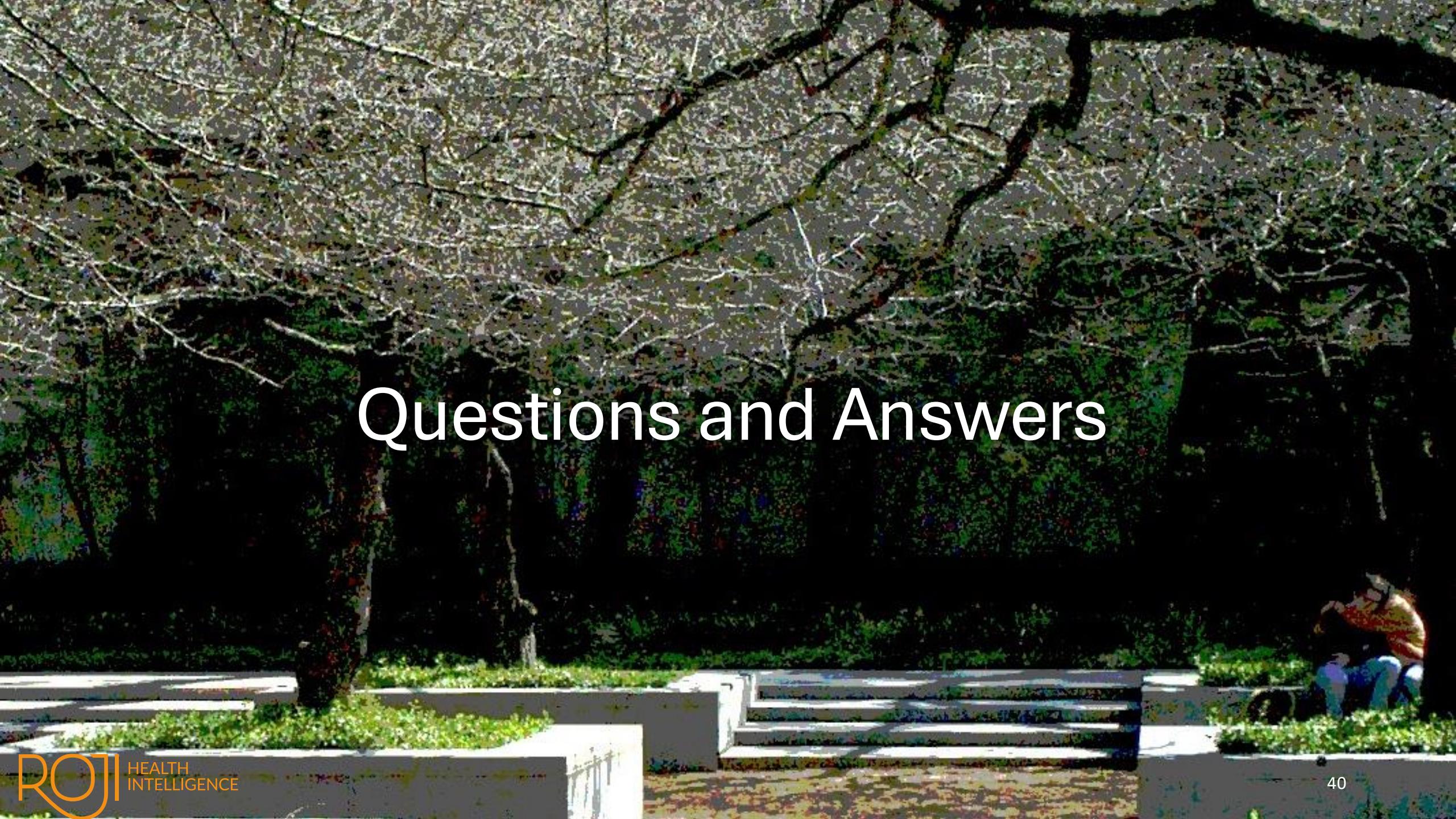
Do you have what's needed to succeed in risk payment models?



A. Maybe not. I hope to avoid it.

B. I'm excited to try.

C. I'm ready to soar.



Questions and Answers

Stop by our VBC Exhibit Hall Virtual Booth



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