Policy Implications

Boot camp 201 – Data and Analytics

HHS/CMS Senior Leadership Takes Shape

RFK Jr.

- **Heather Flick,** Chief of Staff
- ***Stefanie Spear***, Principal Deputy Chief of Staff

- **Russel Vought,** OMB Director
- **Theo Merkel,** Domestic Policy Council
- **Dr. Joel M. Zinberg**, National Economic Council

Dr. Oz

- ***Stephanie Carlton*,** Chief of Staff
- ***Kimberly Brandt*,** Deputy Administrator, COO
- ***John Brooks*,** Deputy Administrator, Chief Policy and Regulatory Officer
- **Chris Klomp,** Director of Medicare
- **Alec Aramanda,** Deputy Director of Medicare
- ***Abe Sutton*,** Director of CMMI
- ***Drew Snyder*,** Director of Medicaid

HHS Secretary RFK Jr.

"President Trump has asked me to do three things:

1. Clean up the corruption in our government health agencies.
2. Return those agencies to their rich tradition of gold-standard, evidence-based science.
3. **Make America Healthy Again by ending the chronic disease epidemic**."

CMS Administrator Mehmet Oz, MD

- Proponent of Medicare Advantage (MA) and has expressed concerns about coverage gaps for innovative technologies.
- “A concerning percentage of American hospitals and medical groups [have a] fee-for-service model, which has created dysfunctional and expensive incentives in health-care for decades, also suffocated their cash flow when the pandemic limited lucrative medical procedures…
- We could achieve [our] goals by buying health-care coverage for every American who is not on Medicaid through the Medicare Advantage program, which a third of Medicare beneficiaries already use very successfully.” (2020)

Trump Administration: Key Themes

- **Healthcare was not a campaign priority**
- **Robust and free competition**
  - Policies that increase supply of healthcare providers in rural areas
  - Offload risk from the government
- **Patient choice**
  - Control of healthcare dollars with the patient
  - Sustainability and value for beneficiaries
- **Provider autonomy**
  - Avoid irrational reimbursement schemes
  - Reduce regulatory compliance burdens
    - Emphasis for rural
    - End quality measurement complex
    - Move away from restrictive and complicated FFS approaches to VBC approaches
  - Unleash innovation
- **Transparency**
- **Reduce fraud, waste, and abuse**

Trump Priorities for VBC

Project 2025 Highlights

- Regulations to reinstate:
  - MCIT: expedited coverage for FDA-designated breakthrough devices
  - RADV
  - MAQI: exempt providers from MIPS for participating in MA VBC arrangements
  - GPDC, currently known as REACH
- Needed statutory changes:
  - VBC: replace FFS with VBC payments; eliminate MSSP; remove barriers to direct primary care; ensure shared savings and reference pricing benefits consumers
  - MA: default option for enrollment, reconfigure risk, remove restrictions on benefits/services; give beneficiaries direct control of dollars
  - Price transparency: codify and strengthen, revisit No Suprises Act
  - Remove restrictions on physician-owned hospitals

Trump Priorities for VBC

Paragon Institute

- Eliminate VBC
  - End MIPS and other pay-for-performance programs; CMS should facilitate reporting and publication of all-payer data that is useful to patients, payers, other third parties
  - Eliminate AAPM incentives, if retained focus on all-payer participation, proportional bonus based on level of adoption
- Enact permanent payment reforms in traditional Medicare such as episode and population-based payments
- Reduce overpayments and reform PFS to incorporate market-based pricing (e.g., MA rates)
- Recent policy brief: Two Pathways for Medicare's Future: MA and ACOs

VBC Addresses Trump Priorities

- Focus on health
  - Reduction of chronic illness burden
  - Focus on primary care
  - Focus on nonmedical contributions to health (nutritional, behavioral)
- Robust and Free Competition
  - Groups of providers compete, with insurers as well
  - Pathway for providers to take on risk
  - *MSSP is on-ramp to higher risk models like GPDC, small rural/independent need significant time with lower risk to progress to direct contracting/capitation*
  - All providers should have pathways for managing risk of populations
- Patient Choice
  - Additional choice for healthcare coverage, driven by patient provider selection
  - Patient autonomy with supportive management from ACOs
  - Patients receive enhanced benefits beyond what's covered in Medicare*
- Provider Autonomy
  - Moves away from FFS structure and regulatory burden
  - Tech-enabled healthcare
- ACOs serve a critical role in identification of fraud, waste, and abuse; led the identification of massive catheter fraud

VBC Provider Priorities

- Retain and boost competition through sustainable pathways for APMs
  - Incentives to join value across all lines of business
    - VBC options available across Medicaid and Medicare Advantage
  - Ensure long-term financial viability for VBC
    - Aligned benchmarks across ACOs and MA: more comparable prospective trend approaches
  - Stable physician payment
- Enhance patient choice by allowing patients to choose VBC entities
  - Enhanced beneficiary education on options for DC/ACOs
  - Expanded voluntary alignment, explore alignment with MA
- Provider autonomy
  - Simplify quality measurement: streamlined approach that can be used across payers and uses measures meaningful to patients
  - Create pathways for all providers to participate in VBC arrangements
  - Continue to shift payment arrangements away from FFS; promote payment arrangements within total cost of care (primary care, specialty payments)
  - Expansion of allowable services/benefits for providers at risk: expanded and simplified waivers

NAACOS' Immediate Priorities for VBC Providers

- Competition
  - Extend GPDC until 2030, create a pathway for permanence
  - Direct Primary Care (i.e., ACO PC Flex) available for all risk-bearing MSSP ACOs
  - Direct GAO/ASPE to conduct a report on benchmarks (policies that increase/decrease participation, comparability to MA)
  - Require MA to report on VBC contract availability and adoption
  - Ensure stability in MSSP by adjusting ACPT to reflect actual spending
- Patient Choice
  - Align GPDC and MSSP voluntary alignment, simplify, remove restrictions for homebound patients
  - Eliminate follow-up beneficiary notification
- Provider Autonomy
  - Make all REACH waivers available in MSSP; eliminate waiver burden (simple reporting metrics)
  - Create a process for ACOs to apply for custom waivers
  - Quality: remove PI requirement, retain WI until 2030, test reporting approaches that will benefit payers, patients

Revisiting Past Trump Admin Approaches

- Geographic Direct Contracting
- Rural Focused Model (CHART)
- Mandatory risk
- Mandatory participation

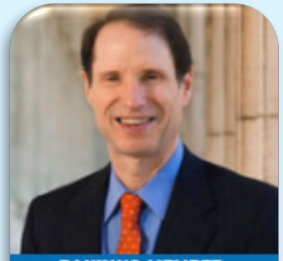
Senate Committee Leadership

Finance Committee

CHAIRMAN

Sen. Mike Crapo

(R) (ID)



RANKING MEMBER

Sen. Ron Wyden

(D) (OR)

HELP Committee

CHAIRMAN

Sen. Bill Cassidy

(R) (LA)

RANKING MEMBER

Sen. Bernie Sanders

(I) (VT)

House Committee Leadership

Energy & Commerce

Rep. Brett Guthrie
(KY-02)

Rep. Frank Pallone
(NJ-06)

Health Subcommittee

Rep. Buddy Carter
(GA-01)

Rep. Diana DeGette
(CO-01)

Ways & Means

Rep. Jason Smith
(MO-08)

Rep. Richard Neal
(MA-01)

Health Subcommittee

Rep. Vern Buchanan
(FL-16)

Rep. Lloyd Doggett
(TX-37)

2024 Health Extenders

- In November, twenty-two of the nation's leading health stakeholder groups sent a letter calling on Congress to extend Medicare's AAPM incentives & stop physician payment cuts.
- Political disagreement stalled progress on bipartisan health agreement that included Medicare extender.
- Congressional leaders are looking for a path forward to address these health priorities in 2025.

AAPM Incentives

One Year

3.53% Incentive & Threshold Freeze

Doc Pay

One Year

2.5% Pay Update to Offset 2.8% Cut

Extenders

5 Year Hospital @ Home Extension

2 Year Telehealth

Congressional Update

2025 Government Funding Timeline

2025 Short-term Advocacy

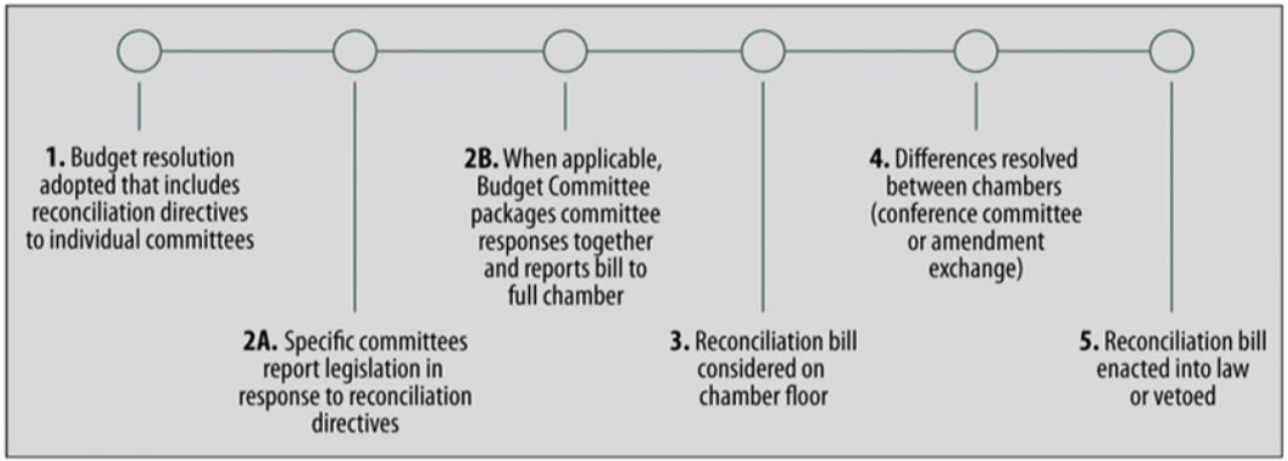
- Lawmakers in the House and Senate introduced legislation that would extend the AAPM incentives and address physician payment cuts.
- House Members introduced bill to delay eCQM requirements & pilot test.
- Committees and leadership working to try and identify path forward to address govt funding & Medicare extenders.

Budget Reconciliation

GOP Budget Reconciliation Priorities

- Extension of Tax Cuts and Jobs Act Policy
- Immigration & Energy Funding
- Government Funding Reductions **($2.5 trillion)**
  - **Key Health Cuts On the Menu:** *Site-Neutral; Medicaid Reforms; ACA Changes*

Figure 1. Major Stages of the Reconciliation Process



Source: Congressional Research Service.

Medicare Payment & Reporting Bills

Preserving Patient Access to Accountable Care Act

- Extends Medicare's AAPM incentives @3.53 percent for payment year 2027 and maintains 2024 revenue and patient thresholds for qualifying APM status
  - ***Bill Sponsors:*** Reps. Darin LaHood (R-IL); Neal Dunn (R-FL); Suzan DelBene (D-WA); Kim Schrier (D-WA)

Medicare Patient Access and Practice Stabilization Act

- Stops Medicare's 2.83 percent payment cut for 2025 and provides physicians with a 2 percent payment update for the remainder of 2025 (April 1- Dec 31).
  - ***Bill Sponsors:*** Reps. Greg Murphy (R-NC); Mariannette Miller-Meeks (R-IA); Claudia Tenney (R-NY); Carol Miller (R-WV); John Joyce (R-PA); Jimmy Panetta (D-CA); Kim Schrier (D-WA); Raja Krishnamoorthi (D-IL); Ami Bera (D-CA); Raul Ruiz (D-CA)

Healthcare Efficiency Through Flexibility Act

- Delays mandatory eCQM reporting until 2030 and maintains all reporting options (including Web Interface). Requires CMS to pilot test prior to mandatory eCQM transition for ACOs.
  - ***Bill Sponsors:*** Reps. Vern Buchanan (R-FL); Dan Crenshaw (R-TX); Jimmy Panetta (D-CA)

Medicare Bills Under Development

ACO Assignment

- Rep. Adrian Smith (R-NE), Rep. Suzan DelBene (D-WA), Sen. John Barrasso (R-WY), Sen. Sheldon Whitehouse (D-RI) working to reintroduce bills to expand ACO assignment to more non-physicians.
  - VBC stakeholders have raised challenges with cost concerns regarding specialist NPP attribution.

Hospital Site-Neutral

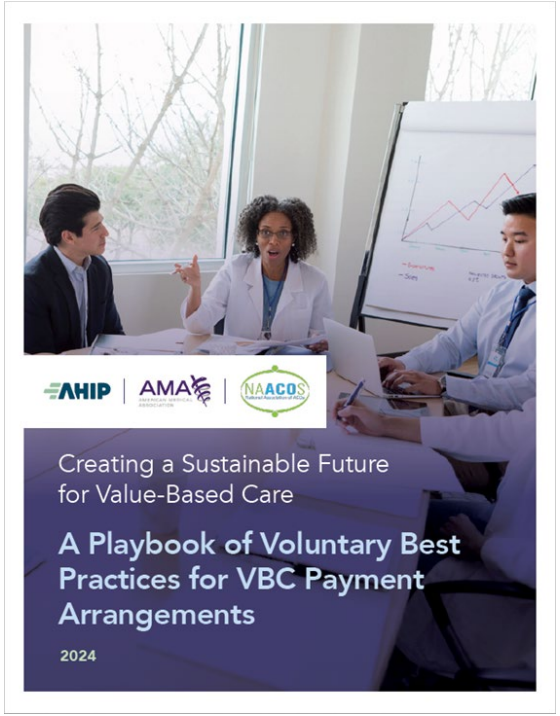
- Sens. Bill Cassidy (R-LA) and Maggie Hassan (D-NH) introduced a bipartisan legislative framework to reform hospital site-neutral payments.
  1. Establishing Site-Neutral Payments in Off-Campus Hospital Outpatient Departments
  2. Establishing Site-Neutral Payments for Common Outpatient Services
  3. Reinvesting into Hospitals
     - Rural Hospitals (Sole Community; Low Volume; Medicare Dependent)
     - High Needs Hospitals (Core lines of service; payer mix; uncompensated care etc.)
     - Value-Based Reimbursement (Bonus payments for two-side risk APMs)
       - **Option 1:** Receive an increase in reimbursements or higher capitated payment rate (PMPM)
       - **Option 2:** Rural and safety net hospitals would have benchmarks set using baseline spending prior to site-neutral changes and slowly phase out over 2 years as APM moves to risk
- Site neutral payment reforms could save $100-300 of billions over a 10-year budget window.

Recent & Upcoming NAACOS Activities

VBC Playbook Series

AHIP, AMA, and NAACOS established a collaboration to identify principles and voluntary best practices to foster sustainable success in value-based care (VBC). The playbook series is intended to advance the adoption of VBC.

- Playbook of Voluntary Best Practices to Advance Data Sharing—Focused on data sharing, as a fundamental building block of VBC
- Playbook of Voluntary Best Practices for VBC Payment Arrangements—Focused on underlying payment arrangements that seek to align payment with performance on quality, cost, and patient experiences
  - Webinar recording
  - Presentation slides



NAACOS, AHIP, AMA's Future of VBC Data Playbook

The maturity model for major functions of data collection, exchange, and use demonstrates how VBC participants can incrementally increase technical capabilities over time.

Data Functions	Current Common Practices	Desired State
Capture	Digitized Records (e.g., EHR, common assessment tools) without standardized data elements	Discreet data elements using industry content standards, which facilitates data extraction and reusability
Exchange	• Manual reporting with spreadsheets • Secure File Transfer Protocol (SFTP) • Point to point connections	• Universal acceptance and use of data networks • Use of industry exchange standards (e.g., FHIR using open APIs) • Automated data processes
Analytics	Siloed aggregated data	• Disaggregated spending and service data • Population health level data sets leveraging external data sets to add value and context
Presentation	Multiple digital formats not integrated with clinical or financial data systems	• Standardized digital formats • Integrate data into EHR platform or dashboard with actionable insights • Contextual information and stratification

NAACOS, AHIP, AMA's Future of VBC Data Playbook

Common Themes Across Data-Sharing Best Practices

- **Data Privacy:** Rigorous privacy and security protocols help to mitigate the risk of inappropriate disclosure and specifying the purpose of data use may increase trust for data sharing for clinicians and patients.
- **Lack of Data Standardization:** The lack of widespread adoption of exchange and content standards and variable participant capabilities make it challenging to share the data necessary to ensure VBC success.
- **Varying Data Infrastructure:** There is wide variability in how VBC participants currently leverage data and technology. Each uses different technology solutions to collect data, process data, and share data-driven insights to improve the value of care.
- **Potential VBC Participant Readiness:** It is important for organizations to assess their options and select the most suitable data-sharing methods that align with their operational capabilities and compliance obligations.
- **Federal Health Information Technology Requirements:** The Centers for Medicare & Medicaid Services, Office of the National Coordinator, and other federal agencies address data exchange standards for public payers such as Medicare and Medicaid in guidance and rulemaking, which influences industry-wide adoption.
- **Financial Investment:** Effective participation in VBC requires a substantial technical and staffing infrastructure, which can come at a significant upfront expense for VBC participating practices.

NAACOS, AHIP, AMA's Future of VBC Data Playbook

Voluntary Best Practices for Data Sharing

1. **Create an Interoperable Data Ecosystem:** Adopt consistent content and exchange standards to simplify and expand data sharing.
2. **Share More Complete, Comprehensive Data:** Empower value-based care participants with complete, accurate, and consistent data that paints a more comprehensive picture of a patient population.
3. **Improve Data Collection and Use to Advance Health Equity:** Collect and share data to identify and address health disparities as well as barriers to care beyond the clinical setting, while ensuring transparency, appropriate use, and confidentiality.
4. **Share Timely, Relevant, and Actionable Data:** Prioritize sharing focused insights and data early, often, and in accessible ways, to improve care.
5. **Share Data Methodologies, Calculations, and Context:** Share detailed information on how and what data were derived from to foster trust among VBC participants in the data they receive, use, and by which performance is measured.

Community Engagement

- Resource on new HRSN codes in Medicare (in progress)
- Webinar on financial contracts/sustainable funding options for CBO/community care hub (CCH) partnerships (Q1-2)
- Joint resource with P2ASC on value proposition for ACOs/VBC entities contracting with CBOs/CCHs (Q2-3)
- ACO/VBC best practices resource with case study spotlights (Q3-4)
- Exploring opportunities for partnership matching (in partnership with P2ASC)

Deep Dive on Specialty Care Engagement

Key Topics to Address

- Patient Population– defining area of care and patient population (patient cohort, episodic, disease-specific)
- Payment arrangement: cap, sub-cap, withholds, risk adjustment, stand-alone v. fit within TCOC
- Rewards and Incentives
- Variation across LOBs
- Rural and Underserved Populations

Activities

- Pre-conference sessions with providers and payers
- Resource on emerging best practices for specialist engagement
- Broad stakeholder convening on policies to advance specialist adoption of APMs

Health IT Policy Landscape

MSSP Quality: Reporting

- Sunsets the Web Interface options for MSSP ACOs in PY 2025.
- Extended MIPS CQM reporting option for MSSP ACOs for an additional 2 years (PY 2025 and PY2026).
- Sunsetting of Medicare CQMs will occur no sooner than five years from now.
- Extended the eCQM reporting incentive (a lower quality performance standard) to continue encouraging ACOs to report via eCQMs.
- Extended the MIPS CQM reporting incentive for an additional 2 years (PY 2025 and PY2026).
- Added a Complex Organization Adjustment beginning in PY 2025 for all APM Entities who report eCQMs, which would provide additional points added to an ACO's quality score
- Will score Medicare CQM performance against flat benchmarks for a measure's first 2 performance years.

MSSP Quality: APP Plus Measure Set

- Goal: Align with the Universal Foundation measure set

Performance Year	Finalized New Measures
PY 2025	Breast Cancer Screening (Quality #12)
PY 2026	Colorectal Cancer Screening (Quality #113)
PY 2027	Initiation and Engagement of Substance Use Disorder Treatment (Quality #305)
PY 2028 or 1 year after the eCQM specification is available	Screening for Social Drivers of Health (Quality #487) Adult Immunization Status (Quality #493)

Provider Requirements

- From ONC/ASTP, Certification of EHRs
  - Certified EHRs must have the capability, through standardized APIs:
  - to respond to requests for a single patient's data,
  - and respond to requests for multiple patients' data as a group.
  - ONC continues to update, through regulation, the standards for those APIs

- From CMS, hospitals and MIPS providers must use certified technology and show data exchange by participating in TEFCA, exchanging data with other providers, and making data available to patients

Provider Requirements: Prohibiting Information Blocking

- Health care providers must make all EHI available to patients in an agreed upon electronic format, with little to no cost to the patient. This may be done through a portal, via USB or CDs, or through apps on a patient's phone (e.g. Apple Health).
- Health IT vendors must provide electronic copies of data to health care providers when the provider wishes to change vendors, enabling them to import data seamlessly into a new system. This eliminates a significant roadblock to changes IT systems and vendors.

Health Plan Requirements: Required APIs

- **Patient Access API**: a secure, standards-based (HL7 FHIR Release 4.0.1) API that allows patients to easily access their claims and encounter information, including cost, as well as a defined sub-set of their clinical information through third-party applications of their choice.
- **Provider Directory API**: Make provider directory information publicly available via a standards-based API.
- **Payer-to-Payer Data Exchange**: exchange certain patient clinical data (specifically the U.S. Core Data for Interoperability (USCDI) version 1 data set) at the patient's request,

Applies to Medicare Advantage (MA) organizations, state Medicaid and Children's Health Insurance Program (CHIP) Fee-for-Service (FFS) programs, Medicaid managed care plans, CHIP managed care entities, and Qualified Health Plan (QHP) issuers on the Federally Facilitated Exchanges (FFEs), (collectively "impacted payers").

Upcoming Health Plan Requirements

- Provider Access API - share patient data with in-network providers with whom the patient has a treatment relationship.
- Make the following data available via the Provider Access API:
  - individual claims and encounter data (without provider remittances and enrollee cost-sharing information);
  - data classes and data elements in the United States Core Data for Interoperability (USCDI); and
  - specified prior authorization information (excluding those for drugs).
- Impacted payers must maintain an attribution process to associate patients with in-network or enrolled providers with whom they have a treatment relationship

Upcoming Health Plan Requirements

- Payer-to-Payer API - make available claims and encounter data (excluding provider remittances and enrollee cost-sharing information), data classes and data elements in the USCDI and information about certain prior authorizations (excluding those for drugs).
- Impacted payers are only required to share patient data with a date of service within five years of the request for data.

Upcoming Health Plan Requirements

- Prior Authorization API- populated with its list of covered items and services, can identify documentation requirements for prior authorization approval, and supports a prior authorization request and response.
- Required standards for these APIs are:

  United States Core Data for Interoperability (USCDI)
  HL7® Fast Healthcare Interoperability Resources (FHIR®) Release 4.0.1
  HL7 FHIR US Core Implementation Guide (IG) Standard for Trial Use (STU) 3.1.1
  HL7 SMART Application Launch Framework Implementation Guide Release 1.0.0
  FHIR Bulk Data Access (Flat FHIR) (v1.0.0: STU 1)
  OpenID Connect Core 1.0

Proposed HIPAA Security Rule

- Based on OCR Audit results, changes in technology, industry requests for clarification
- Eliminates addressable specifications and makes all specifications required
- Expands documentation requirements
- Sets timelines for recurring actions
- Requires MFA and encryption
- Comments due Mar 7.

TEFCA

- The Trusted Exchange Framework and Common Agreement (TEFCA) continues to expand
- eClinicalWorks has been designated as a Qualified Health Information Network (QHIN)
- Further implementation of FHIR Roadmap for TEFCA Exchange is moving forward

Health IT Regulation, Road Ahead

- Interoperability has been a bipartisan issue, but views of new administration are unknown
- New ASTP/ONC head has not been nominated
- Outstanding regulatory issues:
  - Updates to HIPAA standard transactions
  - Finalizing attachment transactions (X12 or FHIR or both)
  - No Surprises Act transactions for GFE and AEOB