

# The Real Registry Advantage for ACOs Reporting Via APP: 5 Myths Debunked

written by Dave Halpert | June 3, 2021



The clock is winding down on the CMS Web Interface, and the reality of mandatory quality reporting via the [Alternate Payment Model Performance Pathway](#) (APP) for ACOs in 2022 is setting in. In order for ACOs to develop and execute their APP quality reporting plan in time to avoid catastrophe, it's imperative to begin evaluating options now.

ACOs, however, have staged a push-back to the APP based on a number of assumptions about their impact on ACO economics, success in reporting, and elements of reporting. A lot of these are simply untrue, based on faulty assumptions about reporting through the APP. For many ACOs without a single EHR (and even some that do), there are misconceptions about registry reporting. These include cost, ease of reporting, accuracy, data currency, and reporting differences.

It's time to debunk the myths and lay out the reality of reporting via the APP, as well as differentiate between registry and EHR reporting.

## Myth #1: Reporting under APP Is Prohibitively Expensive for ACOs

Many ACOs believe that reporting under APP would be extraordinarily expensive because of required data gathering, as well as the level of effort to achieve performance.

The Reality: Not true. An advanced registry can deploy different data collection methodologies by practice or data source in a manner that is both comprehensive and economical.

The word “interface” hits resource-strapped ACOs and practice IT departments like a shockwave, sparking fears that department budgets will take a massive hit from vendors’ support and development teams, while timelines on existing projects will be set back.

But that assumption is based on data aggregation practices that many advanced registries don’t use. While there are certain minimum data sets required to successfully report quality measures, there are also many ways to package that information and securely transmit it from Point A to Point B. If the required data elements are already included in an existing output file, an advanced registry need only establish the secure connection with you, taking the effort out of creating a new file. If a required data element (or elements) are missing, an advanced registry will help you to determine what is missing and the most cost-effective method to compile and send it (a “flat” file, an established standard like [FHIR](#), or a combination of several data types).

This flexible approach also mitigates burdens associated with measuring and improving performance. Following training and validation, timely uploads of data files combined with rapid processing ability make it easy to track ongoing performance. If there are gaps, an advanced registry can work with you to determine whether these are gaps in data or gaps in care. If the former, an advanced registry will work with you to determine where the data in your system(s) resides and to establish a process for integrating it. If the latter, that advanced registry can develop strategies with you to improve and to measure the ongoing effects of your efforts.

## Myth #2: ACOs Can Report Quality More Successfully Through EHRs

The Reality: Not true. You will actually do worse reporting eQMs through your EHR(s) than MIPS CQM through a registry. Why? Because this myth has two flaws: it assumes that EHR data is always complete, and that reporting is a solely technical process. Let’s address these two separately.

The “complete data” fallacy can be seen both globally and locally.

Just because your ACO is able to report on at least 70 percent of an eligible measure denominator, CMS expects 100 percent of that denominator in your file submission. In other words, even if you report on 100 percent of what is likely 90 percent of your population, you may have mathematically covered the 70 percent data completion threshold, but you have not actually fulfilled the CMS reporting requirements.

Furthermore, [Quality Data Reporting Architecture](#) (QRDA) files may be sufficient for individual systems and practice Tax Identification Numbers, but adding scores together, even if each practice has been able to do so, yields inaccurate and unacceptable results. APP measures are designed to be reported at the ACO level and are to be reported once per year per patient (See Myth #4). If a patient sees multiple practices, adding files together from each practice duplicates numerators and denominators, and invalidates measure calculations.

In addition, customized EHR templates and interfaces create data gaps in pre-programmed eCQM templates. In the real-world EHR balancing act, if care isn’t documented, it didn’t happen; but if it can’t be documented easily, it won’t be documented at all. To deal with providers’ EHR documentation fatigue, many organizations have created different workflows for providers, varying by factors including clinic location, patient population, provider specialty, and dozens of others. Further complicating an automated data collection and export process are all the variations in how users are trained on these templates, and how they’re actually used by each individual. Simply put, data reported from the “predicted” data pool may not be complete.

This brings us to the notion that reporting is just a technical process. Unlike EHRs, where quality reporting is a technical add-on to their basic value, the main business of advanced registries is measuring and reporting Value-Based Care. For example, when reporting on an outcome measure like MIPS CQM 001 (Diabetes: Hemoglobin A1c Poor Control) or MIPS CQM 236 (Controlling High Blood Pressure), a missing result in an eCQM is a performance failure. With an advanced registry, however, it’s the starting point to understanding where the data resides and finding the values in your data to increase your performance, by giving you an ongoing view of measure completion and performance that highlights these missing elements, and helping you to identify next steps. Ideally, you’ll move to the point where eCQM reporting is less of a risk. An [advanced registry that is ONC-certified](#) to report on eCQMs can pivot with you.

## Myth #3: Registries Only Require a Sample of Patients

Some ACOs confuse the data completion threshold with permission to use only a sample of patient data.

The Reality: Not true. The “data completion threshold” is 70 percent of the eligible denominator, but in registry reporting, CMS *prohibits* sampling and/or “cherry picking” of patients in a practice.

In the APP, quality reporting via the [MIPS CQM](#) method means that CMS will score the measure in the same manner it does for MIPS. Briefly stated, the measure denominator is defined according to which patients met the denominator criteria in the measure specification. These criteria are specific to the measure, and may include age, gender, a certain diagnosis and/or procedure code, etc. Once the denominator is established, all applicable responses are assigned to the numerator.

For example, a patient between 18 and 75 was seen in the office and received a diagnosis of diabetes, putting that patient into the denominator. The patient’s most recent A1c value is the numerator and is designated as either “performance met” or “performance not met.”

CMS refers to the total numerator divided by the denominator as the “Data Completion Rate,” and mandates that at least 70 percent of eligible patients are reported in order to assign a performance score to the measure (measures with less than 70 percent data completion earn zero points). Performance is calculated by looking at the number of “performance met” responses divided by the total number of responses (after subtracting the number of denominator exceptions, if applicable).

Some (less scrupulous) registries once advertised that they would improve their clients’ performance scores by excluding the “performance not met” measure responses for MIPS scoring, artificially inflating performance. Not surprisingly, CMS established rules to eradicate using a “cherry picking” methodology to report. But most advanced registries are looking for more accountability in quality and cost, so that they can [help their ACO clients achieve higher goals](#).

## Myth #4: Registry Reporting for MIPS CQMs Will Show Outdated Results

Because registries must collect data from EHRs, ACOs often assume that this takes time and creates delays in information available to ACOs and their practices.

The Reality: Not true. Most advanced registries collect on a frequent schedule, even daily, to provide timely and actionable feedback to practices or ACOs.

The purpose of a registry is to help its clients measure and improve patient health outcomes over time; apply insights, support and technology to effect change; and to measure the results. Measuring outcomes over time, costs associated with episodes and conditions, and even measure results are long-term endeavors, and a real-time data interface, while feasible, is not the best use of a registry's clients' resources.

In contrast, the purpose of an EHR is to ensure that providers have all of the necessary clinical information to make informed and educated decisions with patients regarding treatment (and to ensure proper reimbursement). Quality reporting is an add-on. Real-time data for reporting looks great on paper but adds little benefit to successfully reporting on the three APP quality measures.

That does NOT mean that quality reporting through a registry will preclude you from proactive efforts throughout the year. Our clients send data in intervals from monthly to daily, depending on their own needs and resources, and results are updated as data is received. What's more, as issues are encountered, a registry can help you dig into the reason for the issue, and work with you to resolve it.

## Myth #5: Reporting APP Through Registries Limits Measure Quality Results

Some ACOs believe that registries only use claims or direct entry to populate measures.

The Reality: Not true. This myth assumes that registries do not collect provider data. In fact, advanced registries have collected provider data for years, capturing discrete clinical data from EHRs and incorporating all relevant patient services data. At Roji, for example, we have been collecting clinical, demographic, and billing data from provider systems since 2003.

Registries also integrate data from disparate EHRs and other data repositories, providing more accurate measurement to fuel reporting and ACO population health. Advanced registries with sophisticated technology and experience can track a single patient across the continuum of care, even when there is not a shared Medical Record Number between systems (and most times, there is not!). From a quality measure perspective, this means that an ACO can correctly define a measure's denominator and apply the appropriate measure numerator, even when those two elements do not come from the same system. This makes it easier to meet quality completion and performance.

For example, if a patient with diabetes is seen by a podiatrist in the office, that patient will fall into the denominator for MIPS CQM 001 (Diabetes: Hemoglobin A1c Poor Control). Because the patient also saw the ACO's attributed primary care provider (PCP) and had a recent Hemoglobin A1c test performed (along recorded result), the registry also captured that data. The registry will identify that (a) the patient is eligible for the measure one time, rather than two, and (b) use the actual clinical value (e.g. 6.5 percent) to fulfill the measure in accordance with the CMS measure specification. The enhanced data will help improve ACO coordination of care services and ensure more accurate quality performance.

In summary, each ACO will be faced with unique challenges as CMS transitions from its Web Interface to APP reporting. In the short-term, the most important thing that you can do is to plan ahead for the APP in its inaugural year. To ensure that your efforts empower your ACO in ways beyond simple reporting, develop a longer-term strategy that determines how you'll use this additional data. Measure responses need not be swept into an administrative process for meeting requirements, but rather, used as key performance indicators for disease progression and condition management.

Finding a partner who will work with you on a flexible and adaptable strategy will set you on the right path and put you in the best position to improve in future years.

*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: [Vlad Zaytsev](#)