Catapult Your Performance Using the APP and Achieve Data Sufficiency

written by Dave Halpert | December 1, 2022



In a previous post, we demystified the Alternate Payment Model

Performance Pathway (APP) and explained how, by partnering with a Clinical Data Registry experienced in data aggregation and result submissions to CMS, you can avoid the bugaboos falsely attributed to APP reporting—perceived high costs and impossible timelines. Here we'll show you how to leverage your new skills to elevate your ACO's performance across the board, from quality scoring to effective patient management—and achieve data sufficiency, in the process.

Achieve Better Scores and Insights from Quality Reporting

Once your ACO's data from all practices is aggregated, you will be ready to report either the Electronic Clinical Quality Measures (eCQMs) or the MIPS Clinical Quality Measures (MIPS CQMs). (Learn about the differences here.) In either case, the 2023 Physician Fee Schedule Final Rule eases performance requirements and offers potential bonus points for those with a high rate of underserved patients.

For those who make the APP transition before it's required, the standards that ACOs must achieve to earn Shared Savings are reduced: In 2023, as long as the data completion threshold (70 percent of the total denominator) is met, one of the APP outcome measures need only reach the 10th percentile for quality, with others needing to reach the 30th in order to be eligible for maximum shared savings.

By comparison, Web Interface reporting currently requires the 30th percentile on all measures. In 2024, APP reporters can still have an outcome measure in the 10th percentile, provided the others reach the 40th; Web Interface reporting will require all measures at or above the 40th performance percentile.

In addition to these performance safety nets, there are opportunities for positive scoring adjustments. ACOs who serve a high proportion of underserved patients are eligible for a Health Equity Bonus, which can boost your quality score by up to 10 points.

Successfully reporting quality measures via the APP is your starting point toward improving health care—identifying gaps in care, patients who have not met performance standards and are candidates for ACO interventions, patients with adverse events who need visits, risk scoring, and so on. Identifying patients with poor outcomes, alone, is not actionable without a deeper data dive to pinpoint possible explanations, which is much easier to do with data that tracks patients across the entire network.

If a patient has a behavioral health diagnosis but has not seen a clinician who specializes in behavioral health, you have identified a potential contributing factor to high intermediate outcomes. By addressing the reason for this persistent poor control, you can act before these intermediate outcomes lead to disease progression, complications, Emergency Room visits, and admissions. This proactive approach is not only better for your patients, but also your efforts will be reflected in the next round of quality reporting and, ultimately, will lower costs.

Promote ACO Ability to Manage Risk, Costs, and Outcomes

Your clinicians don’t operate in a vacuum of payer-specific clinical care. Neither should your ACO be limited in its ability to create a high standard of care for all patients, so that your clinicians are engaged in accountable care. Including

all patients in your database enhances your ACO's ability to manage complex populations and ensures that you won't be caught in "small numbers-based" assumptions about your data. Conversely, clinicians who are required to base their services in a population-specific way are less likely to engage in your improvement strategies, because it requires more work.

In addition, data that is missing elements hurts ACO improvement efforts. For example, if a patient has a diagnosis of chest pain at a primary care practice and follows up at a cardiologist, an ACO can see that the patient is being managed aggressively. Without integrated data that identifies unique patients and their services, you cannot distinguish a patient who has not been seen at all and a patient who was seen at a different location. In this situation, the ability to be proactive can be, quite literally, a life saver.

Aggregated and integrated data create the potential for creating episodes of care in specific chronic conditions and for procedures and treatments, enabling comparisons of costs and outcomes from patient to patient and from provider to provider.

For patients with chronic conditions, the behavioral health example above illustrates how the ability to track a unique patient across the network can reveal barriers to better health. There are dozens of similar scenarios: knowing whether a patient with a high hemoglobin A1C and who is obese has seen a nutritionist or dietician, or whether a patient with COPD who has had an exacerbation in the last 12 months has seen a pulmonologist.

With additional SDOH data, you can decode these episodes to determine if progressive clinical failure actually stems from poor patient compliance or other factors. Does the patient have persistent poor control in HgbA1C because they aren't following the treatment plan or because they can't afford more effective medication? Interventions must be targeted to the actual cause of therapeutic failure, in order to fix it. Distinguishing therapeutic inertia from legitimate reasons for poor compliance helps your ACO map strategies for community referrals and other population health activities. Being proactive and setting priorities are essential—but without integrated data, you severely limit your ability to use data most effectively and efficiently.

On the procedural side, you must be able to identify specialists who are helping to produce the best outcomes at the lowest cost for your patients. Integrating your claims and all-patient data from providers will enable you to compare results across practices and providers. You can use this data to create stronger partnerships with specialty practices, addressing the 40-60 percent of costs generated by these clinicians.

ACO-specialty collaboration need not be punitive, and it can be mutually beneficial for both parties. Comparing outcomes and services among providers can help you ask the right questions. For example, if one specialist's procedures tend to produce more potential drivers of high cost compared to another, you can investigate. It could have nothing to do with the provider in question—perhaps an issue with the facility, a patient clinical issue, or the use of a particular anesthesia agent—but without being able to see the data from each practice, your ability to compare costs associated with an episode of care is

informal, at best.

Expand Value-Based Care Arrangements with Private Health Plans

Your ACO will have a stronger financial foundation if your patient base is larger and younger on average. If you are formed exclusively for Medicare, it is much harder to take risks. But to make this leap to ACO contracting with commercial plans, you will need the technology and data to support payer-specific data, quality measures and reporting, and analytics. Your clinical interventions may need to be payer-specific because of benefit plan inclusions or exclusions.

In any case, your data must start with provider data systems while you negotiate and build the payer claims data that many commercial plans are unwilling to release. Your ability to contract with private health plans in addition to Medicare will fuel growth and engagement for your clinicians, but requires a knowledgeable contracting strategy. Of course, before entering into these arrangements, do your homework—patient-identified claims won't be a part of your arrangement unless they are in your private health plan agreement!

Some ACOs balk at the idea of a two-sided risk model in addition to all-patient reporting, but it makes contracts with private health plans much easier to negotiate. Although the market continues to evolve, a current advantage of private health plan arrangements is that risk-based payments have been less common. Create your capacity now for these arrangements with small, payer-specific populations. This strategy can build your expertise while you are adopting technology and gaining data. This is increasingly recognized by providers—in fact, the

number of patients currently covered by private plan ACO arrangements is greater than those in Medicare ACOs.

Build Capacity to Live in the Population-Based Payment World

CMS and other payers have united against continuing Fee-for-Service reimbursement. Most in the payer industry are moving toward population-based payments, but many also acknowledge that it might be necessary for the industry to create mandatory models to lure providers away from Fee-for Service.

Physicians are already recognizing that population-based payments and Value-Based Care arrangements are inevitable. They are moving to corporate health care through equity or payer practice purchases and ACO enablers backed by capital. Much of the change in physician attitudes is due to the volume drop-off during the pandemic, where health care spending decreased at a greater rate than overall consumer spending. Physicians have become acutely away of the inconsistency of fee-for-service revenue, as well as how a population-based reimbursement ensures a stable revenue stream.

But you must have built the Value-Based Care infrastructure to be able to succeed under population-based payments. That’s the key promise that corporate medicine has made to physicians and the reason why physicians are willing to take the gamble. Your key first step, aggregating all-patient data that can be activated in Value-Based Care Technology, starts with the very data you need to report for APP.

Value-based reimbursements supported by both provider patient data and all-inclusive, patient-identified claims data will

give you the fundamental ingredient you need to participate and succeed in value-based reimbursements: data sufficiency.

In short, you can turn the APP into a springboard for improvement, growth, and engaging your clinicians. Partner with a Clinical Data Registry that is qualified as a Third-Party Intermediary. Then use your data in real Value-Based Care technology to perform the best quality reporting, episodes of care analytics, and interventions to target and improve patient outcomes and costs. Using that information, align your compensation and reward structure internally, expand your patient reach, and empower your population health.

The APP is about a lot more than how you report quality. It is your segue to having greater knowledge and tools to transform the health care of your patients and community.

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: Jörg Angeli