No Worries About ACO APP! It's Your Pathway to Improvement

written by Dave Halpert | November 17, 2022

With the release of the 2023 Physician Fee Schedule Final Rule, CMS upheld its commitment to sunset its Web Interface for ACO quality reporting after 2024. Beginning in 2025, ACOs will be required to report through the Alternate Payment Model Performance Pathway, or APP.

Some have expressed concerns about the APP. But this new reporting process actually has some significant advantages. It presents ACOs with a valuable trove of data to advance along the path toward better outcomes, health equity, and curtailed costs. In fact, the baseline for APP—data from provider systems, including their EHR data—is the foundation for data sufficiency needed for Alternative Payment Models, including risk-based reimbursement.

To ensure that your ACO is ready for the APP transition and to reap those benefits, it's imperative that you understand the APP itself, where the challenges lie, and how you can harness it to improve your ACO's standing and patient care, both in the short- and long-term.

What Exactly is the APP?

The APP is a method of reporting quality measures for APMs, including ACOs. The CMS Web Interface is sunsetting after the 2024 performance year, meaning that ACOs have a maximum of two more performance years to transition from reporting on a subset of Traditional Medicare patients to reporting on all patients. Note that "all" doesn't just mean "All Medicare" (including Medicare Advantage, for example); it truly means *all patients*, regardless of whether they are covered by private insurance, other public coverage, or paying out-of-pocket.

ACOs report three measures via the APP, rather than ten when reporting through the Web Interface. These three will look familiar, as they are part of the existing Web Interface pool:

> Diabetes: Hemoglobin A1c (HbA1c) Poor Control (Quality ID 001);
> Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID 134);
> Controlling High Blood Pressure (Quality ID 236).

The APP also includes a pair of measures that CMS will calculate through an analysis of its administrative claims, along with the CAHPS for MIPS survey. Those three metrics do not need to be reported by the APM entity, but that entity will need to find a CAHPS survey vendor.

The sharpest contrast between the APP and the CMS Web Interface is that the number of patients goes from a maximum of 248 per Web Interface measure to an uncapped APP denominator that will likely include tens of thousands of patients. For an ACO that has been auditing charts and manually entering quality data into the CMS Web Interface, the potential APP denominators are daunting. Chart abstraction is simply not a feasible solution. The only way for an ACO to report on these measures is to electronically harvest all of the results.

Some have questioned the legality of all-patient reporting, as CMS has neither the ability to see which non-Medicare beneficiaries are eligible for measurement, nor the authority to view their records. This is addressed in the manner of the submission. Rather than reporting the individual patient details to CMS, the measures are reported in the aggregate—the number of denominator-eligible instances, the number of total responses, and the number of responses by type: performance met, performance not met, or a denominator exception (e.g. a patient refuses to participate in a screening for clinical depression). No individual patient data is submitted to CMS; patient privacy remains protected.

To summarize: The APP requires fewer measures, but all patients. It is an accepted reporting option because the results may be captured electronically and submitted to CMS at the

aggregate level. Many EHRs are already able to perform this function, reporting specific versions of these measures called Electronic Clinical Quality Measures (eCQMs).

Everything sounds like smooth sailing until you look at the measures themselves. That's where the process can seem daunting.

All-patient reporting has been part of the non-APM MIPS reporting process since MIPS was introduced by MACRA legislation, beginning in performance year 2017. However, while MIPS reporting practices are often on the same EHR, making it easier to harvest the data, this is not universal. Many large systems have groups on multiple systems and with multiple TINS, making it necessary to integrate the data to ensure that patients can be cross-populated by provider services in the aggregated group.

So, What's the Controversy?

APP measures require the most recent value for each unique patient, and the connections between EHRs are not so straightforward as a data submitter's connection to the CMS API. Many ACOs with disparate EHRs are not able to identify unique patients from one source to the next. Medical Record Numbers vary by system, and data privacy concerns mean that fewer patients are providing Social Security numbers, ruling out that method of matching. (For the record, however, experience has shown us that SSN was less of a useful identifier than expected.)

So, while each EHR may be able to perform these calculations within its active provider lists, there's no "all ACO" view unless the ACO integrates practice data and uniquely identifies individual patients across the ACO. This aggregation is not as simple as adding each EHR's scores together, which produces invalid results. Since measures require the most recent values for unique patients, simple EHR aggregation will double- (or more) count patients in APP measure denominators, although only one of the measure numerators should be used.

This means that an ACO comprised of multiple practices will need to deploy more sophisticated technology that tracks a patient across the continuum of care, calculating quality measure numerators and denominators at the ACO level for all patients. That's a new bar for ACOs.

But APP Concerns are Based on False Assumptions

The belief that all-patient reporting through the APP will not be feasible for ACOs is tied to the two Big APP Myths, both of which are demonstrably false:

Big Myth 1: APP reporting is prohibitively expensive.
Big Myth 2: APP reporting cannot be accomplished within such a short time.

Here's how you solve the data aggregation conundrum: partner with an Advanced Clinical Data Registry that has qualified as a Third-Party Intermediary. These firms can take data from disparate sources, aggregate the information and use their experience to match patients between one entity and another, and create a unique patient record that reflects all services from across the system. Simply put, they ensure that the John and Jane Does in one practice should (or should not!) be matched with the John and Jane Does in another.

This gives you the true count of unique patients and the most recent results for each, meaning that you can accurately see and submit your quality measures to the APP. The system works for both eCQMs and MIPS CQMs, so if your partner is ONC-certified, they can submit either version, depending on your ACO's needs.

Not only does a Third Party Intermediary solve the reporting problem, but also it can execute the process more quickly and efficiently, for less cost, than a series of vendor-driven EHR-to-EHR interfaces. Better still, should an EHR within the system have limited options for packaging and sending data, some Third Party Intermediaries can blend the QRDA files used for eCQMs with non-standard files. If a required data element is missing, your Clinical Data Registry partner can work with you to determine the most cost-effective manner of retrieving it (e.g. a targeted data query, an established standard, or a combination). For those who have waded into the depths of EHR migrations, implementations, and interfaces, you can rest assured that the timeline is weeks, rather than months (or even years).

Two Options for APP Reporting

As for the reporting itself, there are two options for reporting these measures: Electronic Clinical Quality Measures (eCQMs) or their MIPS counterparts (MIPS CQMs). Both track the same information, but they're calculated slightly differently.

The eCQM version prohibits any manual intervention; the measure is calculated by the EHR based on patient eligibility and whether the clinical data is documented in the appropriate spot.

MIPS CQMs provide more latitude. Patient eligibility is still fixed, but the numerator data may be obtained in several ways, including targeted data queries. Customized workflow templates can help speed up documentation during a visit, but when that eCQM is calculated, the information in the template may not be synced with the field that the EHR is using for calculations, and performance will suffer.

On the other hand, a MIPS CQM's numerator can use the results from the template, even if they're stored in a different table than the one that the EHR uses to populate measures. In an ACO where documentation is inconsistent from one practice to the next (and sometimes, even in that same practice), having a partner who can use files that can be manually cobbled together or direct entry, this can be a game changer.

Having a comprehensive view of your ACO will also bring advantages far beyond quality reporting. In a future blog, we'll explain how ACOs can leverage the view they need for quality reporting into a more holistic, value-based care approach, including the management of complex populations—particularly the ability to identify patients who are at risk for high-cost outcomes (or worse) and appropriate interventions. It will also give you the ability to demonstrate clinical excellence to other health plans and use this to your advantage during contract negotiations. Having the full picture enables you to create a proactive, rather than reactive approach, and will promote shared savings. Most importantly, it will mean better health and a better clinical experience for your patients.

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