To Unlock ACO Access to Real Savings, Start with Trusted Data

written by Theresa Hush | August 22, 2024

Value-Based Care payment models are based on a clear CMS goal: lower Total Cost of Care and its counterpart, Total Per Capita

Cost. But neither TCoC nor TPCC gives you the information you need to target your cost efforts. How to start? Begin by evaluating what initiatives you need to do in the five key areas:

- Community Referrals
- Avoid High-Risk Events
- Cost Variation
- Chronic Disease Intervention
- Physician Episode Sharing

Your ACO may look at these five areas and think many of them are already underway through population health and other activities. But while population health efforts can help get patients services, they cannot change the course of treatments for patients who are not improving or evaluate variation in care. To make any clinical improvements in care, you will need to engage your physicians. Those physicians must be equipped with data that they trust.

First, Examine What Data You Have

To examine your possibilities, look at these five key areas in connection with the type and quantity of your existing data. Your ability to improve patient health and manage costs is dependent on the amount and type of data you can harness. With small amounts of data that don’t include all the necessary patient information, you can do some initiatives, but not a lot. The scale and efforts for your ACO will vary by volume of patients, payor mix and demographics, and the strategies you create in each area.

The Reality of a Low Data Approach

As we outlined in a previous article, you can start initiatives to improve outcomes and manage associated clinical costs with limited quality data that you are already collecting for your ACO.

Measure data for 2025 APP Reporting won't generate a lot of savings, because the numbers will be small. If you use a Medicare CQM method to report data to CMS, it will be further limited to avoiding hospital and ER events for patients based on clinical factors. The APP Measure values, to be most useful, should be gathered over a longer time period to identify the patient's trend, and be part of a multi-factor risk assessment.

Data will also depend on your data source. QRDA 1 data is generated to satisfy quality measures only, and therefore will not provide related outcomes, such as obesity for patients with high HgbA1C and uncontrolled blood pressure. For example, QRDA data would be insufficient to identify patients who are good candidates for continuous glucose monitoring or community social services.

Nevertheless, QRDA measures can provide a list of patients with high HgbA1C and uncontrolled blood pressure that could be matched with claims data on events and form a basic project for ensuring that patients have met visit requirements. It can also be used to form a base for importing other data for more focused initiatives, and thus provide valuable lessons about how to use data to engage physicians in improvements. Such data may also provide value on screening your population of patients with social factors preventing access to care. If you have no funds or ability to aggregate data from your participants'

EHRs, you can at least start here.

Strategic Initiatives Need High Data Value

Each of the five key areas must be backed by a specific set of clinical data, which requires that your sources enable that data to be aggregated. Comparisons based on clinical data are essential if you want to engage physicians in improvements. You should realize that all EHR data does not have equivalent value. Value varies based on data source, data extraction type, time, clinician documentation, and even implementation of the EHR itself.

Each aggregation methodology has pros and cons, and the cons don’t apply just to QRDAs. Use of flat files to report data for aggregation are excellent for transactional data, but not always for some clinical data points that may be stored through EHR specialty-customized templates, and therefore require staff resources to produce. Flat files are not interoperable data, and although they can be a great source for a group that has no alternative methodology or database, they must be generated by Information Technology staff. FHIR connections, the highest standard for data aggregation and the source aligned with high-value continuous data feeds, are just now being accepted by some participating providers and their ACOs.

ACOs are often comprised of multiple groups on different systems. Some groups are still using paper records or are on old systems without data export capabilities. The acquisition of data for the purpose of all initiatives—cost as well as quality strategies—will depend on ACOs facilitating their practices’ modernization and adoption of fewer, certified systems with FHIR application setups and sandboxes for

analytics vendors.

Data Is Just the Starting Point—It Must be Energized by Analytics and Sharing

Your ACO will likely depend on a data aggregation and analytics vendor to aggregate, integrate, and energize your data. These vendors are, like Roji Health Intelligence, often in the business of meeting other business needs, such as quality reporting or clinical integration.

Minimal data aggregation involves claims, EHR transactional and clinical data, and disparate sources of clinical data. The target for this data is a database that is the center of your Value-Based Care platform, internal or vendor-created, and which fuels your strategies. It should be able to connect to other operational systems like EHRs and population health, and must share data with clinicians. Without information sharing and feedback loops for clinicians, your ACO cannot achieve trusted data.

The platform should have functionality for costs analysis, but should also involve the next step: to set up improvements via shared data among clinicians by specialty or collaborating groups, or clinical teams. The platform should also be able to break down the data into comparable units of measurement to identify costs. For example, an examination of costs for specialty services, divided into various specialties or even procedures, is not actionable. How much is not enough or too much? Your objective should be to calculate services provided to a patient, with both outcomes and costs, in a way that is consistent with optimal clinical care over a time-delimited period. Patient Episodes allow you compare patient cases and

examine for variations, complications, or other items that drive the cost higher (or lower).

Episodes of Care are the vehicle for comparison with others. Patient Episodes of Care are different from payment-driven episodes like Bundled Payments or other Episodic payments used by payors to cap reimbursement levels. The goal is to create episodes with clinical integrity that can serve as a vehicle for a true comparison of patient outcomes, services, and costs, for conditions and procedures that are defined by the same set of diagnosis or procedure codes.

Four of the five key areas are informed by Episodes of Care for either patients with chronic illness or patients undergoing treatments and procedures:

- Avoid high-cost Events for high-risk individuals;
- Narrow cost variation by identifying cost drivers and possible issues in clinical delivery;
- Engage patients in change; and
- Share data with physicians to guide clinical examination of costs.

The path to data-driven Value-Based Care is detailed and tolerates few shortcuts without compromising data that is trusted by clinicians. But the result of all that effort is well worth it: Clinicians who willingly use trusted cost and quality data to improve your patient care and manage costs, so that your ACO shines.

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.

5 Ways Your ACO Should Leverage Data for Cost Control

written by Theresa Hush | August 22, 2024

In creating your strategies for cost control, your ACO must consider how to reduce Total Per Capita Cost (TPCC) while ensuring the financial survival of your ACO and participating providers. This balancing act is the dilemma facing all providers adopting Value-Based Care: how to achieve more savings while replacing revenue lost from services. Here's how data can guide your efforts to sustain your ACO while stewarding high quality and affordable care:

Total Cost of Care Is a False Starting Point

If you are looking at Total Cost of Care (TCOC) or TPCC as your primary metric for cost control, you're on the wrong track. Aggregating your health care service costs to a payer and for a population of patients is not informative except in comparison with other groups. Nor are those total costs, in isolation, actionable. To affect TCOC or TPCC, you need to address the situations that affect those total cost metrics, including:

- High or inappropriate utilization or services;
- Costs that spin out of control but can be managed;
- Patients sent outside your network where there are no linkages to your primary care or population health.

You can’t simply tell your providers that they need to reduce cost of care. The only strategies to achieve that would cut services without improving patient care:

- Benchmarking costs by provider/practice through incentives and penalties;
- Requiring prior authorizations for internal controls on higher cost services like diagnostics;
- Directing patients away from services.

Cost-cutting mechanisms aren’t so easily identified as wholly good or bad, however. For example, many ACOs did significant work to reduce skilled nursing facility (SNF) costs by negotiating rates, establishing relationships, and ensuring that patients left facilities when therapies were exhausted. While this is a service redirection, a coordinated approach of replacing SNF services with home- or provider-based therapy might reduce costs and be beneficial to patients.

Nevertheless, simply lowering TCOC by arbitrary actions may generate one-time savings that require more cuts in future years, because of the ACO cost reconciliation formula—an example of a cost strategy that can work against sustainability.

Better Strategies Avoid and Mitigate Costs, While Spurring Growth

Given an environment where there are severe shortages of physicians in both primary care and specialties, maintaining your focus on coordinating care to avoid high-cost services will make your ACO less vulnerable to excess capacity and costs for providers. This is a wise strategy for the long run, as well, because it will be hard to meet future demand without creating efficiencies and transforming practices so that physicians can manage care teams with the support of other clinicians and staff performing specific care management functions.

Two additional factors are worth noting that improve the economics of physician services. First, with an emphasis on accountable care, CMS is proposing the payment of Advanced Primary Care Management fees to providers even under the Fee-for-Service program and in ACOs. Increased funding for primary care physicians is only one of the benefits; the real enhancement is the recognition and delineation of the work involved in caring for individuals with chronic illness. These are issues that have long frustrated primary care groups.

Second, the Making Primary Care (MPC) multi-payer payment model will also benefit ACOs indirectly, by testing and identifying care management and community-based programs that help to improve outcomes and reduce costs. Both of these initiatives recognize the need for understanding the real work of primary care and right-sizing the economics. ACOs can learn from the programs adopted by the participants and find a promising path toward maintaining robust physician panels in their

organizations.

Finally, data to perform cost control that had been inaccessible is now available to ACOs. Even if you are doing APP Quality Reporting in 2025 with Medicare CQMs, you will have clinical measure data that you can use to your benefit in managing costs.

Five Cost-Focus Areas that Data Can Leverage

Your ACO has potential to make serious headway in the following five areas, using data that can identify patient risks, help physicians communicate with patients, and create the foundation for cost cuts in the right direction. With some or all of these areas, you can build the Value-Based Care track record you need to fuel patient growth.

1. Avoid high-cost utilization and events for patients with chronic disease and poor outcomes.

Clinical and claims data will identify patients who are at risk of events because of multiple high-risk factors, persistently poor outcomes, and progression of disease. These represent additional physician and care management needs to identify causes and evaluate treatment options, while engaging the patient in education and improvement.

2. Narrow cost variation among specialty procedures and treatments.

In clinical episodes for every patient within a set time frame, procedure and treatment data will compare costs of the same

procedures and allow you to drill into causes of cost variation. Provider data-sharing and collaborative initiatives between ACO primaries and specialists will help focus on prevention of complications, clinical pathway adherence, and patient selection to lower excess costs.

3. Engage patients with chronic illness and specialty needs in motivational communication and decision-making.

Patient communication, even with AI tools, can help patients understand their risk factors, touch base with providers, and stay consistent with treatment plans. In specialty cases, a formalized communication of goals and obstacles can help clinician-patient discussions about the pros and cons of treatments.

4. Invest in collaborating and training community organizations.

Working with community organizations to share social and care management functions can add to your resources and help the communities that share patients with you. Your data can identify patients who may be better served by various community organizations to meet their social and financial needs.

5. Guide physicians with clinical cost data that is relatable to their patients.

Physicians don’t need to be overwhelmed by detailed data, and they react negatively to scores. Help them understand the issues by showing them sample patient episodes that reveal both good and problematic results, for better interventions and

improvements.

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CMS Presses for Accountable Care, Better Quality Measurement for Physicians and ACOs in New Proposed Rule

written by Dave Halpert | August 22, 2024

July brings us baseball, fireworks, and CMS's Proposed Rules. In 2,248 pages of proposals, CMS has outlined its plans for MIPS, ACOs, and other Advanced Alternate Payment Models, and how they will transition from fee-for-service into a value-based care arrangement through the Quality Payment Program (QPP).

We already know from the 2024 Final Rule that CMS plans to phase out Traditional MIPS in favor of MIPS Value Pathways (MVPs), and is committed to having all Traditional Medicare beneficiaries in an accountable care relationship by 2030. These Proposals continue to build on that framework, but it wouldn't be a July ballgame or a Proposed Rule without a few curve balls!

To avoid a misstep on your value-based care path, pay close attention to a few key themes in this Proposed Rule:

1. Don’t Be Lulled into Complacency by Lenient MIPS Scoring Policies

Panicking MIPS participants rejoice! Several favorable scoring updates to MIPS seem celebration-worthy, but looking down the road, it’s critical to understand the underlying reasons for these proposals. CMS intends to phase out Traditional MIPS, and while they explicitly say that they are not proposing to do so by 2029, that is the time period they have informally established. With that in mind, it’s easier to understand why there’s less push to stretch the capabilities of MIPS participants next year: they are trying to give all (potentially) 1.27 million of them just enough breathing room so that they are able to begin the shift to MVPs now, in a less risky environment.

In each instance, these scoring proposals incentivize MVP adoption—nothing is intended to bolster Traditional MIPS performance. Holding the performance threshold at 75 points is a perfect example. While the intent last year was to bring the cutoff between penalties and rewards to 82 points, many providers felt that introducing an MVP into the reporting equation would be too risky, especially since 2023 MIPS scores have only recently been released. The same principle holds for retaining the 75 percent data completion threshold for quality measures, reducing the Improvement Activity reporting burden, and maintaining the Promoting Interoperability category as is—they don’t want the transition to MVPs to occur on shaky ground.

2. MIPS Quality Category Updates Intended to Drive Specialty MVP Participation

From the 2024 Proposed and Final Rule, it was clear that CMS wanted to see MVP adoption among specialists, and was even considering bonus points for ACOs whose specialists reported MVPs, in addition to the quality reporting done through the ACO. The issue for many was that the measure development process has not kept up with CMS's benchmarking process, resulting in instances where certain specialists had extreme limits on the measures that were available for reporting, and those that could be reported had artificial caps placed on the number of Achievement Points they could earn.

To address this, CMS has proposed a new policy for scoring measures that are "Topped Out," the term they use to indicate that a measure's historical performance has been so good that there is no room for improvement (and when a single failure can take you from 7 points to 1). In a departure from the draconian performance benchmarks used to score Topped Out measures today, CMS has developed a 1-10 point performance scale beginning at 84 percent, with the potential to earn all 10 points. Providers who were hamstrung from the outset will have an opportunity earn a sustainable quality score.

This is critical for MVPs, as the MVP quality measures are plucked directly from the larger MIPS measure library. Without a policy in place to make MVPs viable for specialists with limited choices, it was more advantageous for them to remain in Traditional MIPS and report a measure that was tangential to their scope of practice. This new performance scale for Topped Out measures (and the fact that they will only need to report

on 4, rather than 6) makes MVPs an attractive option.

3. A MIPS Cost Category Scoring Update Will Help, but You Need More

In MIPS, Cost is the only category in which no data is submitted; scoring is exclusively performed by CMS through an analysis of its claims. That's already a serious disadvantage for those who don't have access to comparative episodes of care modules that identify deviance from patient outcome trends and clinical standards of care, highlight notable clinical observations for review, and help you to visualize variation in cost.

The reweighting of the Cost category during the COVID-19 Public Health Emergency (PHE) and subsequent absence of Cost category feedback compounds the mystery surrounding Cost category scoring. Not surprisingly, this category had an unweighted mean of 59, compared to the next highest category (Quality), which came in at 74.

Upon examination, CMS found that small deviations on a cost measure could have a catastrophic impact on a provider's cost score. To alleviate this, they propose to modify their scoring methodology that would not disproportionately affect practices and providers who score near the median, but above the mean. This is especially important for Cost measures, as for several, a provider can be held accountable for measure with only 10 eligible cases. In a sample so small, one case can produce seismic changes in scores.

In fact, 2023 results were so curtailed by the existing scoring methodology that CMS has proposed to put the new methodology in

place in the 2024 performance year. This is allowed, as the measures themselves will not actually be scored until 2025, and the payment adjustment will not come until 2026. That may seem like a reprieve; but remember, the absence of ongoing feedback still puts you at a disadvantage, and so without ongoing insights that you can use to improve throughout the year, it's only a matter of time before your scores will suffer compared to other providers', at a cost to you.

4. CMS Continues to Push ACO Development and Beneficiary Coverage

CMS believes that they are on the path to achieving their goal that all Traditional Medicare beneficiaries will be in an accountable care relationship by 2030. One of the pathways to this is ACOs. CMS cites that there were 19 newly formed ACOs in 2024, and that the 480 ACOs across the country covered 10.8 million beneficiaries. Of course, there's a long way to go before that goal is met, and so CMS has made some new proposals to entice ACO participants.

The first proposal is one that offers successful ACOs early access to their expected shared savings, referring to this as Prepaid Shared Savings. To be eligible for these payments, an ACO must be in a two-sided risk arrangement (BASIC Track C-E or ENHANCED Track), and to have consistently earned shared savings in the past, while meeting the Quality performance standard. Finally, CMS must determine that the ACO has not achieved these results by avoiding at-risk beneficiaries.

There are rules for how the prepaid shared savings may be spent—think gift cards, not cash. At least 50 percent must be spent directly on beneficiaries in a way that wouldn't

otherwise be covered by Medicare. For example, meals and transportation would be allowable uses of Prepaid Shared Savings, but services covered under the fee schedule would not. The remaining funds are allowed to be spent on staffing, and on the type of infrastructure that can help you measure outcomes over time, aggregate data, and target populations for interventions. Essentially, CMS is trying to ensure that ACOs are reinvesting the savings in services that will promote value, rather than fuel expansion of the business.

The next proposal is intended to drive ACO participation in rural and underserved communities. Currently, an ACO must have at least 5,000 attributed beneficiaries to participate, and if falling short, must follow a Corrective Action Plan (CAP) to enhance attribution. Failure to reach 5,000 patients by the end of the performance period meant automatic termination. The reasoning is that, with a small sample, calculations for savings and losses are more prone to swings, as one patient has the potential to disproportionately affect the whole.

This Proposed Rule removes the automatic termination provision, leaving it to CMS's discretion. To ensure savings and losses calculations remain valid with a with a smaller sample of patients, a sliding scale based on patient volume, Minimum Sharing Rate (MSR) and Minimum Loss Rate (MLR) is applied, which differentiates statistical "signal" from "noise," and potentially keeps some ACOs in business.

To augment ACO development in rural areas, CMS has taken lessons from ACO REACH, and proposed a Health Equity Benchmark Adjustment (HEBA). CMS claims that REACH has increased safety net provider participation, and to maintain this momentum, they

created the HEBA based on dual eligibility or enrollment in Medicare Part D Low Income Subsidy (LIS). The HEBA would increase an ACO's historical benchmark, enabling them to spend more without incurring losses. Since ACOs caring for underserved populations do not typically see adjustments from regional efficiency, the HEBA is intended to both sustain existing ACOs and drive demand for new ACO formation.

Finally, CMS has proposed a series of Advanced Primary Care codes designed to recognize whole-person, integrated, and accessible care focused on health and wellness through care management relationships with patients, families, and the community, and will (if finalized) play a key role in patient attribution. These codes also effectively expand the definition of "accountable relationships," allowing a potential pathway for meeting CMS accountability of care goals and, potentially, further reimbursements. We will cover these codes and their implications in a subsequent article.

5. Seismic Shifts in ACO Quality Reporting

No, it's not the sunsetting of the CMS Web Interface after 2024—that's old news. Today's headline is that in 2025, CMS is only allowing two options for submitting APP Quality Measures: Medicare CQMs and eCQMs—the MIPS CQM option is proposed for removal. Ostensibly, this is to enable ACOs to prepare for the shift to Digital Quality Meaures (dQMs), as dQMs will use eCQMs as a base. However, the timeline for dQMs is undefined, and as we stand today, there are wide-ranging problems with eCQMs:

> Their specifications are overly complex and lack standardization.

> They are not automated; generating and processing QRDA files is extremely taxing on both human and machine IT resources. They do not fit into existing workflows, leading to a disproportionate number of false negatives (the response is in the record, but not in the precise field the EHR checks). They are not culled from multiple sources; they come from each provider's EHR alone, potentially leading to duplicates across ACO providers.

In addition to these issues is the fundamental problem with the Quality Reporting Document Architecture (QRDA) files that underpin eCQMs: they only are generated for patients who have triggered the quality measure, and only include information on that specific quality measure. In other words, they are limited to measure response values only, so that any other use besides quality reporting is deeply restricted. In this respect, Medicare CQMs actually offer a better path to cost control than eCQMs. Insisting on QRDA-based eCQM builds doesn't break down barriers between quality reporting and patient. It builds them.

This will not always be the case (hopefully); as Fast Health Care Interoperability Resources (FHIR) APIs are developed, the building blocks of these measures may be updated to facilitate accurate quality measurement, while also enabling the exchange of data necessary for creating a strategic map for cost control. This reality has not been realized yet, however, and steering providers into a method on the cusp of change due to lack of transparency and accuracy seems ill-advised.

To make the eCQM transition more palatable, CMS is proposing additional quality points. They propose to extend the current

bonus quality standard for ACOs who report the APP using eCQMs. ACOs may still meet the performance standard by achieving the 10th decile on at least one of the 4 outcome measures and the 40th decile on at least one of the remaining measures. They have also proposed "Complex Organization Adjustment" in the form of one extra achievement point for each eCQM submitted by an APM entity that met data completion and case minimum requirements.

Finally, they have proposed to retain the provision that a failure to meet this standard will not prohibit the ACO from earning shared savings. The sliding scale enabling partial shared savings could be a fixture all the way to 2028.

There is another major proposal for ACO quality reporting. In addition to the type of measures allowed in the APM Performance Pathway (APP) reporting, CMS is proposing an expansion of the APP measure set. To align quality measures across programs, CMS has adopted the Universal Foundation of Quality Measures, and this requires broad applicability. Although the three measures actively reported in the APP are applicable to many, and can be utilized to generate savings, they simply do not cover enough ground.

To address the gap between attributed patients and the number of patients included in quality measures, CMS is rolling out Phase 2 of the APP– APP Plus. The APP Plus would add 5 Adult Universal Foundation Measures incrementally from 2025 to 2028, for a total of 8 reported measures, plus the 2 CMS calculates through claims and the CAHPS survey measure. The additional measures reflect CMS's priorities in preventive care and screening (breast cancer and colorectal cancer screening, an

adult immunization composite), behavioral health (Initiations and Engagement of Substance Use Disorder Treatment) and health equity (Screening for Social Drivers of Health).

6. RFIs And Solicitation of Feedback Galore: Make Your Voice Heard!

Within this Proposed Rule, there are several instances in which CMS is either formally initiating a Request for Information (RFI) or is informally soliciting feedback, including:

- Services Addressing Health Related Social Needs (HRSNs)
- Aligning FQHC/RHC Services Paid Under the PFS
- Payment for Coordinated Care Referrals Meeting Unmet HRSNs
- MVP Development, Deployment, Adoption and Performance Assessment
- Creation and Structure of a Total Risk/High-Risk ACO

These specific requests are in addition to your ability to provide feedback on any component of this Proposed Rule. To make your voice heard, visit https://www.regulations.gov/document/CMS-2024-0256-0001 before September 9, 2024 to comment.

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Image: Jose Morales

Strategies for Right Now to Control Patient Care Costs

written by Theresa Hush | August 22, 2024

Policymaker confidence in Value-Based Care and the Accountable Care Organization (ACO) model has, so far, prevailed despite only small overall savings. There is still enduring belief that ACOs can rationalize health care and produce affordability by transformative strategies. But here's where wishes and reality conflict: ACOs have, until now, lacked the data and tools to transform health care. The ACO savings results support the promise but not the delivery of affordable health care.

The fact is that ACOs must deliver on the affordability of the promise, or as the shift to risk payment models continues, there will be financial consequences for ACO providers. And now is the perfect time to start, since new patient data is becoming available to ACOs that gives them greater ability to better reduce patient risk and patient utilization.

Providers and ACOs Have a Greater Ability to Control Costs

What is the vision for ACOs that policymakers and financers of health care can't achieve on their own, through cuts and payment model incentives? How can your ACO be more successful in lowering the cost of care than you have demonstrated so far?

Your physicians have clinical knowledge for directing optimal patient care. They also have the closest relationship with patients. Their actions will influence total patient costs, whether directly through diagnostics and treatment, or indirectly through communications and forward planning with patients. *But you must identify patients who are on a downhill slide and get your clinicians involved, or your providers are powerless.*

Specialized skills, expertise, and knowledge build the pathway for change in the patient's health status if combined with effective communication with patients and timely interventions. Health status is the crux of costs; if patient health is poor or rapidly deteriorating, that triggers more clinical events, expensive diagnostics and procedures, and higher costs. If patient health is improving or better managed, those costs will not materialize. Cost control is an adjunct to clinical management, not separate.

ACOs have an ability to identify where these triggers are likely to spark costs and can deploy interventions before they happen. But it depends on having data and using it strategically to identify patients according to their risk level, then effectively targeting timely interventions .

The obstacle has been a lack of clinical data to adequately assess patient risk. ACOs are only beginning to comprehend how that clinical data enhances their efforts. Equally as important, even if you have a lot of data, you must also have the capability to analyze and use it.

How Do You Create a Strategic Map for Cost Control?

All ACOs must start aggregating their participating providers' EHR clinical data into a patient-centric database for Value-Based Care efforts. Together with claims data, this gives you what you need to identify all the diagnoses of your patients as well as their health status. We will delve into the details and complexities of that data in a future article.

But you don't need to delay initiatives. You can start right

now to use the data you already have to initiate cost control.

Your first foray into the development of a strategic map for controlling costs can be iterative. Even if that data is not enough to generate huge savings, creating the analyses and testing interventions to control costs will be essential to your overall plan.

In short, start at Square One: the clinical data you are collecting for the required APP Quality Reporting, which you must start gathering by performance year 2025.

APP Measure Data is Rich for Cost Strategies and Already Available

The three APP Measures require that your ACO provide the latest values for each eligible patient's HgbA1C (for patients with diabetes) and blood pressure (for patients with hypertension). They also require screening every patient for depression and developing a follow-up plan for cases where depression is indicated.

These are important Measures, and there will be many patients. Of the three Measures, hypertension and depression will capture the largest number of patients. Patients with these conditions also have higher potential utilization events. Behavioral health-associated admissions and ER visits are an under-acknowledged source of utilization. Hypertension and its association with stroke and cardiac risk also triggers cost and outcome events. As HgbA1C and blood pressure represent actual values, they will provide strong indicators of patient status.

Additionally, if your data source format for APP data captures

values throughout the performance year, trends for patient outcome data will reveal patient status over time, indicating treatment effectiveness (or not). You can then create patient cohorts at a higher level of risk, based on clinical values and not retrospective diagnoses and utilization, such as HCCs. With that information, you can easily start processes for clinical review and population health interventions.

Three Measures, Three Key Paths for Cost Prevention and Reducing Risk

Initiatives that use one or a combination of the Measure values are a way to make your cost prevention strategies more powerful. Consider just these three possibilities for patients with poor outcomes in one or more conditions:

- Create a high risk pool of patients with poor control in diabetes and hypertension, and assign additional risk factors based on events in claims or behavioral health. Then use the data to refer patients for review of treatment plan, referrals to specialists, or other management programs.
- Create a cohort of patients with depression plus previous events and refer to community behavioral health providers. Set up frequent monitoring of patients through population health.
- For patients with high metabolic disease risk based on blood pressure, diabetes, and other outcomes (e.g. obesity), create screening programs such as cardiac, kidney, and others based on potential disease progression.

Combining measure data will lead you in a variety of directions and provide more ideas for cost control.

Take Advantage of Early Startup

Don’t wait to embark on cost initiatives for fully aggregated data. Reducing costs involves both data aggregation and effective strategies for achieving change in patient status. The latter will require clinician involvement, population health, patient communications, and goal-setting—all of which will take time, because this is a new, proactive approach to medicine. Experimenting with different interventions and methods will produce a better outcome. It will energize your providers about the what can be done with more data.

Generating initiatives with APP measure data makes economic sense. You have already spent the resources to collect and report that data. Now empower your ACO to start an iterative and engaging process for connecting clinical data with cost initiatives. It’s a win-win.

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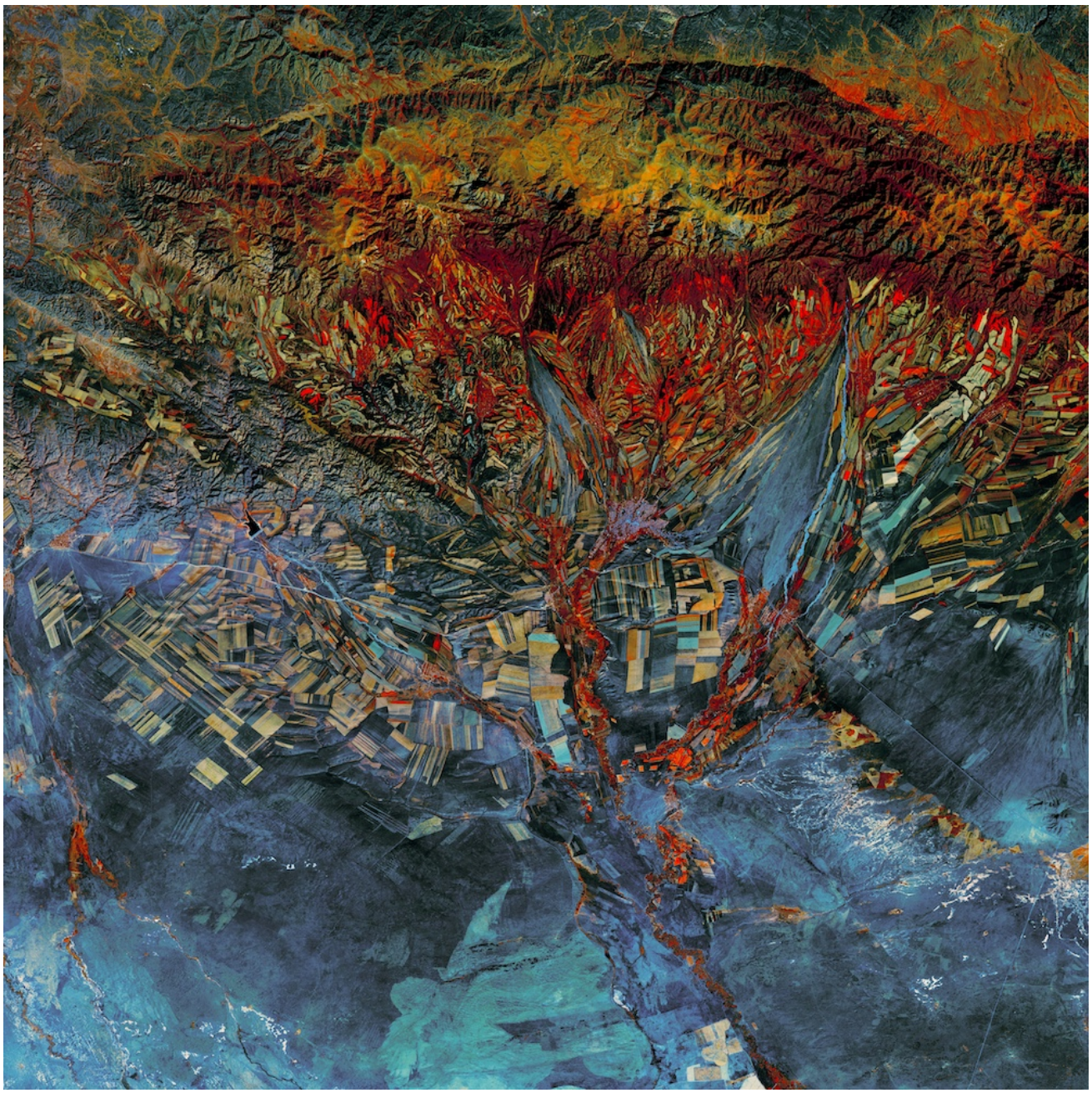
Image: Victoria Ballesteros

ACOs Need a Strategic Map for Cost Control

written by Theresa Hush | August 22, 2024



For ACOs to remain relevant and viable under risk payment models, they must step up now to generate more cost savings for Medicare patient care. Medicare's budget cuts are once again under consideration as political pressure mounts to lower governmental spending. CMS is expanding risk through Medicare value-based payment models, such as the new ACO PC Flex model, which is designed to create per-patient reimbursement for small ACOs in trade for higher reimbursements and funding for infrastructure. Most newer CMS payment models are now

incorporating per-patient payments designed to lower the total cost of care.

As the provider-driven vanguard in the Medicare Value-Based Care effort, ACOs' total savings represent just slightly over 1 percent of $944.3 billion in total Medicare spending. Some ACOs have individually generated higher savings for their patients' care, but others are at zero or in the red. ACOs collectively produced a considerable $10.5 billion in savings in the most recent reported year of 2022. But it is not enough to forestall budget cuts in the program as the fiscal situation tightens.

Why just one percent? The answer isn't complicated: The way ACOs try to reduce costs is, in most cases, not sophisticated enough. And they have lacked the tools to save more.

Soft Sell on Costs in Value-Based Care—Until Now

Cutting costs in health care is fraught with misperceptions, starting with the notion that cost control invariably hurts patients. Those misperceptions have emerged from experience with cost management through prior authorization and benefit cuts by payers and payer-providers. From its inception, the ACO model emphasized that lower costs would automatically result from better coordination of care and improvements in patient health.

ACOs' pursuit of population health strategies to reduce hospital admissions and emergency room visits did produce some savings. ACOs also went after low hanging fruit to reduce costs, such as skilled nursing facility stays for the maximum time frame rather than for the patient's actual therapeutic

needs. But the totals tell the story– the savings from these basic approaches are not enough and won't be enough to ensure the future of ACOs.

Unfortunately, cost control is never "automatic." It requires measurement, understanding and ferreting out cost drivers, cost variation, and other exacting elements of cost.

Escalation in health care costs involves many hidden factors–practice patterns, patient engagement in initiatives to improve health, equitable access and services, and the slow and certain progression of chronic disease and risk factors into more serious and costly illness. Note that many of these factors involve clinical factors and patient-physician communication during care delivery. Addressing these issues will help, not hurt, patients.

Many of the highest costs are incurred from specialty care diagnostics and treatment. But many ACOs have considered specialty care beyond their purview, by virtue of both the reimbursement system and their membership makeup.

Bootstrapped ACOs Have Lacked Data and Tools for Cost Control

Measurement and successful cost control strategies require data. Until recently, most ACOs received quarterly retrospective data from CMS for their patient services. But not all used even this transactional data. Apart from diagnosis information and events, claims data does not contain the clinical information needed to ascertain patient condition or risk level. Thus, population health cannot identify the highest risk individuals except by counting events and comorbidities

associated with claims. There is little predictive capacity in this data.

Since the drivers of cost are clinical, ACOs also need clinical data from their participating physician groups' EHRs to adequately pursue cost control strategies and identify the drivers in cost variation.

In the last year, CMS rules have put greater emphasis on ACO aggregation of data, by way of two new requirements. First, the transition in ACO quality reporting from sample-based reporting to APP Reporting pushes ACOs to begin taking data aggregation seriously in order to perform APP reporting successfully. Second, the recent Quality Payment Program rule changes require ACOs to facilitate a transition of their participating practices to Certified EHRs, making it easier for data aggregation.

It won't be long before ACOs are no longer data-impoverished and will have the means to pursue real cost control in conjunction with clinical excellence and outcomes for patients. But to accomplish that, they'll need a strategic map.

How to Develop a Strategic Map for Cost Control

ACOs will need a number of concerted strategies designed to pursue better patient care and outcomes; many of those strategies will involve linking quality and patient treatment to cost consequences. For those new to EHR data, this is complicated territory. Your ACO needs to know how to navigate data quality, data gaps, priorities for your patients, priorities for the ACO, your physician involvement, and how to evaluate costs.

At Roji Health Intelligence, we've been evaluating clinical information and turning it into cost- and value-based strategies for more than 20 years. We have created a template for ACOs embarking on this journey and are introducing this series to help you navigate the development of initial and ongoing strategies. Over the next several articles, we'll delve into how to launch cost control with a clinical focus.

First up, what you can accomplish using your most readily available data, and how to expand capabilities once data is aggregated on a larger scale. In future articles, we'll present strategies for collaborating with specialists, assess Artificial Intelligence tools, and discuss what you must know as you embark on this mission. We hope you'll share this with your colleagues and take the needed steps now to help your ACO flourish.

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Image: USGS

2022 QPP Experience Report: Address 3 Key Findings Now to Avoid Future Penalties

written by Dave Halpert | August 22, 2024

At first glance, CMS's recently released 2022 QPP Experience Report (PDF) seems reassuring, because the majority of clinicians avoided financial penalties under MIPS. Don't be fooled! While overall success and failure rates in the report may lead you to conclude that merely participating in the QPP (either in MIPS or as an APM) is enough to do well, trends in the report tell a very different story:

Without a concerted and cohesive strategy to simultaneously improve efficiency and demonstrably improve quality, providers will begin to see their consistent results fall short of minimum performance thresholds.

The QPP Experience Report details participation in the MIPS and APM tracks of the Quality Payment Program (QPP). Performance results focus on MIPS, from both the Traditional MIPS

participation and MIPS APM tracks. (MSSP ACO performance results are released separately.)

Although these results are from 2022, there is plenty of actionable information that you can use to your advantage. In particular, there are three critical underlying—yet profoundly impactful—findings that health systems and providers should proactively address in order to avoid (or undo) financial penalties based on their performance in 2024 and beyond.

1. The COVID-19 PHE, and the corresponding proliferation of Extreme and Uncontrollable Circumstance (EUC) Exemptions created a selection bias in the results.

Although understandable, CMS's approval of nearly all COVID-19-related EUC exemptions had unintended, unavoidable consequences. Since providers could easily remove themselves from the eligibility pool for MIPS, only those who believed that they were guaranteed to clear the minimum MIPS performance threshold submitted data. Those who were less confident but aware of the EUC process could easily remove themselves from the performance adjustment pool.

The resulting selection bias explains why only 14 percent of clinicians received negative payment adjustments. This may seem like a minor footnote, but the effects are more pronounced. Since statute dictates that MIPS performance thresholds correspond to prior year averages, this self-selecting group of submitters has earned up to 8 percent in incentive payments; however, artificially inflated performance will make MIPS more challenging for everyone in years to come.

2. MIPS scores actually fell between 2021 and 2022. Maintaining high results will be extremely difficult.

This is primarily due to the fact that the Cost category was finally applied to the MIPS score for the first time in three years. Given the sheer number of specific Cost measures now in play, plus the requirement that certain measures may be scored with as few as 10 cases, overall MIPS scores have become much harder to predict.

Even with perfect scores in Quality, Improvement Activities, and Promoting Interoperability, providers can still fall short of the MIPS Performance Threshold if they fail to control costs. In 2024, the Minimum Performance Threshold is 75 points, and it will increase to 82 points in 2025. With Cost representing 30 percent of the possible score, it can make or break your MIPS performance adjustment. With CMS only providing de-identified results (received eight months after the end of the performance period), an up-front strategy combining cost and quality metrics will be the only way that providers can stay on the positive side of the performance threshold.

3. The APM results are also deceptive, because they reflect a method of quality reporting that is being phased out.

APM Entities did score comparatively higher than both individual clinicians and group practices in MIPS scoring, but that story is missing a critical chapter: the sunsetting of the CMS Web Interface.

The vast majority of ACOs have been utilizing the CMS Web

Interface (rather than the APP) to fulfill quality reporting requirements, but that ceases to be an option after this year. Going forward, ACOs will need to report via the APP. Since 99.88 percent of MIPS APM Entity payment adjustments went to MSSP ACOs, the high scores achieved by APMs in this report reflect a time where only limited technical expertise was required—certainly nothing so complex as comprehensive data aggregation from disparate sources. Expect a sharp drop in scores for those without a plan for creating a patient-centric database that can be used for measuring, improving, and reporting performance.

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Image: Max Langelott

3 Ways Your ACO Can Convert APP Reporting Data into Higher Savings

written by Theresa Hush | August 22, 2024

Controlling costs is a key Value-Based Care goal, a fact well-known to ACOs that share savings with CMS. Even as individual ACOs have generated tens of millions of dollars in savings, however, MSSP ACOs as a whole have only been able to reduce their Total Cost of Care (TCOC) by a fraction. That is a program vulnerability and one reason why value-based payments are increasingly incorporating population-based payment.

Plainly stated, claims data (especially 2-5 months old) isn’t a great tool for identifying patient risks, Medicare HCCs notwithstanding. The timeline for cost prevention is before events occur, not when you’re looking in the rearview mirror. Although using emergency room and inpatient admissions can help you to follow up on patients and possibly forestall future

problems, you may well miss the patients who are next in queue for events but hidden from view because you can't see the risks present in clinical data.

With Alternate Performance Pathway (APP) Reporting, ACOs can do better. Even if you've never collected a bit of clinical data, you have the ability to identify some of your most vulnerable patients through APP Measures. Let's see how that can work to put you ahead of the game and boost your savings.

Use the Tail to Wag the Dog: Focus on APP Data for Cost Savings

Your ACO probably considers APP Reporting as a regulatory program, a necessary requirement for being an ACO. Many providers consider both APP and MIPS quality reporting programs to be a burden. All the more reason that you should use their benefits to enhance your potential savings!

For the majority of ACOs that have not aggregated data from practice EHRs, there has been no clinical information to fuel your cost initiatives. But by using as few as three measures, you can initiate improvements and interventions that can prevent avoidable admissions and their costs.

These three APP measures, required for APP Reporting, capture important outcomes that will be of use to your ACO:

- Diabetes Hemoglobin A1C Poor control Preventive Care (Quality ID 001)
- Screening for Depression and Follow-up Plan (Quality ID 134)
- Controlling High Blood Pressure (Quality ID 236)

Any Method of Reporting APP Measures Will Open Options for Cost Control

You have a choice of three methods for APP Reporting:

- All-patient MIPS CQM Measures,
- All-patient eCQMs, or
- Medicare patient-only Medicare CQMs.

For detail on the pros and cons of these methods, see our tips on choosing your APP Reporting approach.

All three methods will provide you with outcome data for patients with diabetes, hypertension, and depression. But some reporting methods will provide richer data for predicting risk or cost control activities. A detailed data dive is beyond the scope of this article, but here's how each APP reporting method maps to data value for cost control:

- eCQMs generate less-rich clinical data, providing only data that will meet the measure for all eligible patients. You will get HgbA1C, blood pressure values, and depression data, but not all the clinical information needed to enhance patient risk assessment.
- MIPS CQMs capture richest data across all patients. Requiring data aggregation, CQMs allow the qualified reporting registry to pull data from many sources. This will vary across data-aggregating registries. Roji Health Intelligence pulls a large number of clinical values to calculate measure eligibility, to help clients' health systems and ACOs participate in improvement programs and intervention, and to pursue cost control activities. The rich data is used to identify highest risk patients and

those with exacerbations or progression of disease.
Medicare CQMs provide moderate data richness for Medicare patients. If your ACO uses CMS patient eligibility lists for measure denominators, you will still need to gather measure values for the patients. The value of your data will be limited if you depend on data input for those values, but this situation is feasible mainly for very small ACOs. If you can aggregate data from systems, you can generate very rich data for the patients and practices on those systems if QRDAs are supplemented by other data aggregation files.

Three Key Areas to Start Cost Control with APP Reporting Data

While the degree of valuable data will vary across the above reporting methods , you will have clinical data for perhaps the first time to begin cost control and further quality initiatives. Here are three avenues that build your foundation:

1. Create a plan for patients with poor control in diabetes and hypertension (all methods of reporting).

What's in the measure data?

- HgbA1C values
- Systolic and diastolic blood pressure

What are the possibilities?

- Identify patients for review of clinical treatment program based on non-improvement.
- Identify patients based on clinical and medication data for

SDOH review.
Initiate self-management programs, case management for poorly controlled patients and those with exacerbations.
Choose patients for continual glucose monitoring, self-management programs, or case management.

2. Prevent behavioral health (i.e. depression) admissions or complications of chronic disease (all methods of reporting with claims data).

What's in the measure data?

Patients with indication of depression
Patients with depression and without a plan going forward
Patients with indication of depression and with diabetes and/or hypertension

What are the possibilities?

Identify patients without treatment plan and with admissions or emergencies.
With both depression and diabetes, create interventions to manage condition.
Establish referral arrangements to community resources.
Link patients to virtual resources.

3. Identify patient risk for cardiovascular disease and stroke (best for CQM/Medicare CQM methods).

What's in the data?

- EHR data: Patients with metabolic disease markers (A1c, hypertension, obesity, hyperglycemia, dyslipidemia)
- Claims data: hospital and ER events, other diagnoses such as AFib

What are the possibilities?

- Identify patients with multiple indicators and utilization events for higher risk.
- Investigate unknown diagnoses, such as missing hypertension.
- Identify early indications of diabetes with glycemic values.
- Create risk algorithm based on existing conditions plus events found in claims data.

These examples are just a few of many opportunities to blend improvement of clinical outcomes with initiatives to prevent admissions, reduce ER use, and mitigate progression of disease. Yet all of them use data that will be purposed for quality reporting, plus the claims data you already have. Take advantage of required APP reporting to maximize your opportunity for ACO savings and transition to more effective cost management and better patient outcomes.

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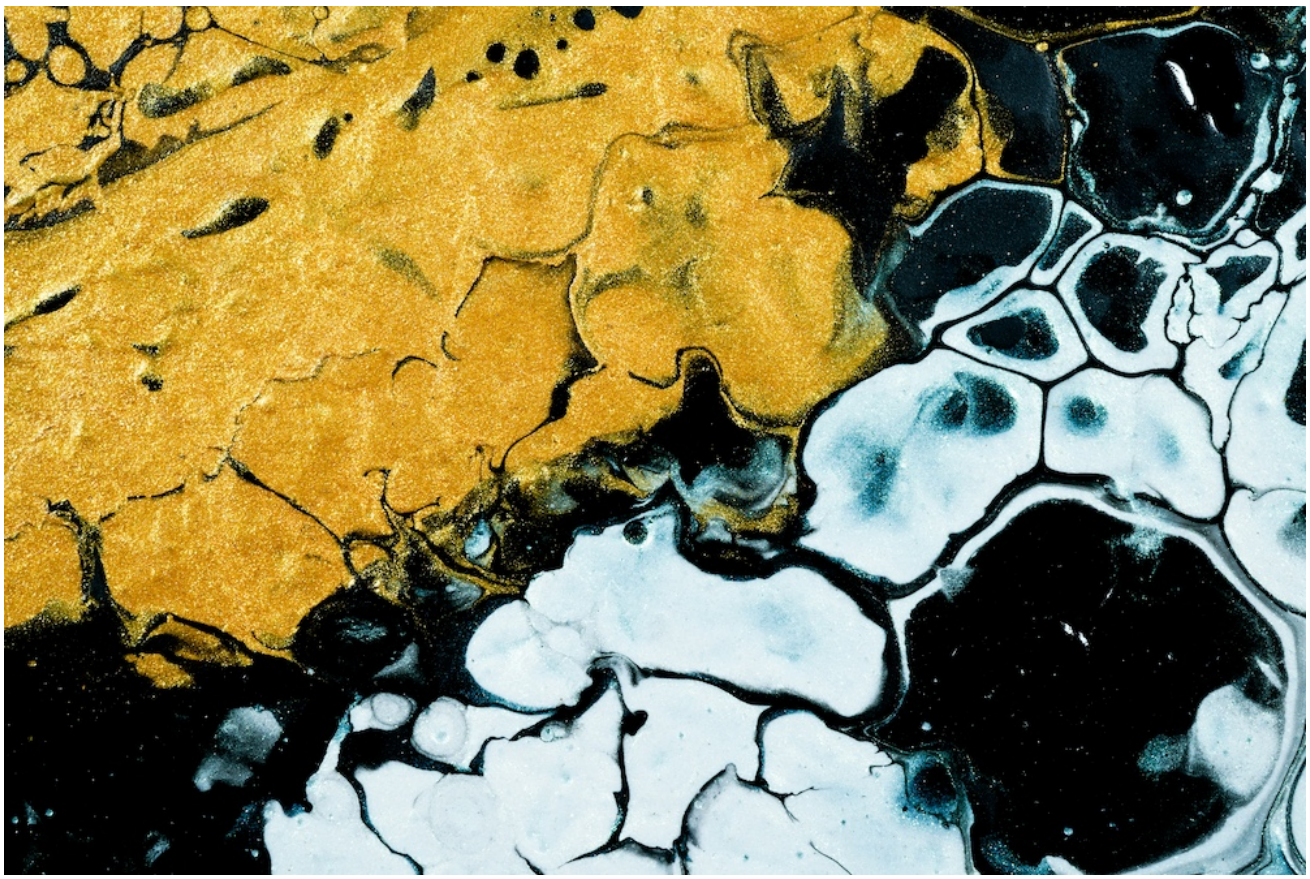
These Five Trends Are Steering Your Future Path to Value-Based Care

written by Theresa Hush | August 22, 2024



Buckle your seat belt. Health care is changing at warp speed. The Value-Based Care movement and leaps in technology and Artificial Intelligence are rapidly generating advances that will transform the health care environment. These factors will redefine health care providers and services, and how consumers access them. How you respond strategically will determine your survival as a health system, ACO, and health care provider.

All of this rests on one essential fact: Value-Based Care in 2024 has graduated from a voluntary movement into certainty. There is arguably no one in health care who believes that there is an "out." While some participants in the health care system are furiously working to get as much as possible out of the elapsing Fee-for-Service engine, everyone understands that time is limited.

To successfully navigate your organization through the turbulence, you must understand these major transitions and take steps to secure your future position in a system driven by value-based revenues. Roji Health Intelligence is committed to helping providers transform health care through data-driven and well-executed Value-Based Care strategies. In future articles, we'll examine how important trends are reshaping health care and provide options to advance your own services and growth. Let's start with an overview of those trends.

Key Trends that Dictate Your Future

1. Corporate health care will expand its reach and build strength.

The pace of corporate acquisitions continues. Optum became the largest employer of physicians in 2023, and more physicians are

now employed by corporate health care than by traditional providers. Capital is flowing into private-equity-backed practices and ACO enablers like Aledade, which commands a large lead over other ACO companies. CVS Health and Amazon both completed major physician group purchases in 2023. Why does it matter? These groups have business models rooted in Value-Based Care and Risk. They are poised to align with payers, but they are also more apt to invest in data and AI tools. They have a history of direct consumer marketing and sales. They want consumers to choose them, and they know how to attract them.

2. Megamergers between traditional health systems will intensify.

Consolidation in health care is not a new story, but the scale is bigger. Health systems that reach coast to coast are emerging, such as the Kaiser Permanente and Geisinger deal that marries a large staff-model health plan from California with a major health system in Pennsylvania. The venture will create a new Risant Health brand, the nation's biggest healthcare network delivering Value-Based Care. Other provider-payer entities are likely to follow. Expect to see large provider systems maneuver for territory in similar multi-state arrangements, because global risk payments and their predictable revenue stream is a huge revenue draw for organizations familiar with risk. Even more important, large organizations' investments in data, AI and other technology over the past several years gives them strength to better manage resources.

3. Data expansion for AI Adoption will surge.

The decades-long digitization of health care data is beginning

to mature. Epic has cornered the largest part of the market; expect many smaller EHR systems to fold in coming years. CMS has mandated that ACOs require participating providers' systems to be certified in the future, but consolidation among providers as well as development of ACOs will also accelerate the trend. Major health systems see health care data as an important asset, and some are experimenting with applying NLP (Natural Language Processing) to turn unstructured data into useful sources for SDOH and other needs. Epic and other large EHRs are already integrating NLP and other AI applications. Another CMS requirement for ACOs requires reporting quality for all patients. Although a Medicare patient-only option has now been allowed for 2024, ACOs are increasingly eager to take advantage of the AI opportunities and coming to realize that it will require data.

4. Physician supply will shrink more, especially in key specialties.

Even in geographic areas with historically dense medical services, shortages are spiking at a time when physician specialties face increasing demands by growing populations of patients with metabolic disease, cancers, cardiovascular diseases, and advanced age. Wait times of up to six months or more are not uncommon, even with insurance benefits backed by a large provider network. The consumer experience is exacerbated by consolidated health systems that have created bureaucratic barriers for patients, like call centers between patients and their existing practices. In response, expect patients to accelerate the trend toward use of retail clinics and urgent care, further deteriorating the bond with and among traditional health care providers.

5. The burgeoning consumer health care market will galvanize consumers to demand value.

Consumers have been vocal about their frustrations with health care for years but had no voice at the table. That’s all changing. Amazon, Walmart, CVS, and Walgreens are already marketing health care services directly to consumers. The consumer wearables market has blossomed, especially demand for fitness trackers, smart watches, condition-specific wearables, and applications to monitor fitness and health, used by more than 22 billion consumers in the U.S. As consumers begin making choices based on corporate health care services and communications, expect traditional health systems to improve communications with patients. Providers will also become interested in data from wearables to improve patient data and relationships.

How Do Your Value-Based Strategies Address These Trends?

If you’re ignoring your market, it will be difficult to compete and appeal to consumers. More important, you won’t have the tools to make value-based payments fruitful. In future articles, we’ll explore connections between market trends and your strategies, including these:

- Do you have the data needed to fuel Value-Based Care initiatives like quality, cost control, and health equity, and is the data strong enough to support Artificial Intelligence?
- Are you participating in new value-based payment models, and how are you including physicians and other clinicians in your value-based care development and execution?

- Are your patient communications, cost transparency, and population health activities really addressing consumer needs?
- Are your initiatives on cost control, outcomes, and health equity showing measurable results?
- How are you addressing practice transformation and enabling physicians to provide better care?

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Image: FlyD

Customized Roji APP Reporting Plan Cuts ACO Costs and Burden, Boosts ACO Capabilities

written by Theresa Hush | August 22, 2024

Start your APP Reporting of Medicare CQMs and save with Roji Health Intelligence's customized APP Reporting Plan for ACOs. Our new service enables your ACO to meet the highest quality reporting standards through our qualified registry, while dramatically reducing reporting costs and creating actionable data for use in population health, equity, and cost performance.

What's at Stake for Large ACOs?

The finalized Medicare PFS Rule released in November 2023 toppled a big barrier for 2024 ACO quality reporting. CMS provided an option to allow ACOs to report measures for Medicare patients only—and of most importance, created the avenue to identify eligible patients for ACOs and potentially avoid aggregating data in 2024 or beyond. Data aggregation has been an issue for ACOs because of cost and EHR capabilities.

CMS clearly realized that many ACOs were composed of practices with systems that lacked data exporting capabilities, and further mandated ACOs to require that their practices adopt certified EHRs in the future.

But APP Reporting through Medicare CQMs has limited potential; that process primarily benefits small ACOs. While smaller ACOs can manually gather data to populate measure results (using a qualified registry reporting application), this is not feasible for larger organizations. The three APP measures will have thousands of eligible patients, making manual data abstraction very difficult.

Roji's customized solution uses CMS patient lists to populate patients in measures and then aggregates data where possible to capture measure numerator data. Our approach focuses on doing what is feasible. It deeply discounts data aggregation costs while allowing your ACO to get started with APP Reporting under less stress and with greater incentives.

Benefits to Roji's Customized Plan for APP Reporting of Medicare CQMs

Here's how Roji's customized plan for APP Reporting of Medicare CQMs works to benefit ACOs and enables your organization to start reporting in 2024:

- Significant savings on fees for APP quality reporting under Roji's blended approach, which reduces fees to less than 30 percent of the all-patient data aggregation cost, and even more for larger ACOs with limited EHR systems.
- Immediate ability for ACO to use aggregated data in population health and other improvements, by identifying all

Medicare patients with poor results.
Easier startup to APP Reporting with relaxed performance standards and additional bonus points available in 2024, before APP becomes mandatory.
Lower threshold for success for APP Reporting. When reporting via the APP, an ACO may achieve just the 10th percentile on one of the outcome measures and still meet the quality performance standard.
Additional quality points through the Health Equity Adjustment for ACOs reporting through the APP.

How the Customized Roji Plan Works

CMS sends a quarterly upload of patients who are eligible for Medicare CQMs, based on the measure specifications and beneficiary attribution. By February of 2025, the list will include all denominator-eligible patients for 2024 (a departure from the Proposed Rule.) For most ACOs, this file will be too large for data abstraction of measure results, especially the final quarter to be delivered during the submission period.
Roji provides method for practices or ACOs to securely submit basic files (with Roji assistance) from EHRs to sync with CMS data, and obtain measure results without burdening practices. Roji uploads this data into our technology for ACO and practice view, accessible at any time. Results are updated throughout the year, so that your ACO can identify opportunities for improvement, whether they are related to clinical outcomes, costs or clinic-level data collection.
Roji provides our input application for practices to provide measure data directly from the EHR throughout the year, for practices where no data aggregation can occur or at the end

of the reporting period.
Roji uploads aggregated results to the CMS scoring engine.
Once results are calculated, Roji creates and transmits files to the CMS measure engine in the CMS-specified method, which ensures that your results are received and scored.

Start Your APP Reporting Efforts at Low Cost This Year

Historical ACO results have shown consistently that ACOs with more experience tend to perform better than those without. With the CMS Web Interface ending its run, it is imperative that you take this lesson to heart. Quality is scored comparatively, and those who take the first APP step before it becomes mandatory have the opportunity to fine-tune their process, giving them an inherent advantage over their peers. Begin the transition now to ensure that you can achieve the Quality Performance Standard and earn Shared Savings in the future. Contact us to learn more.

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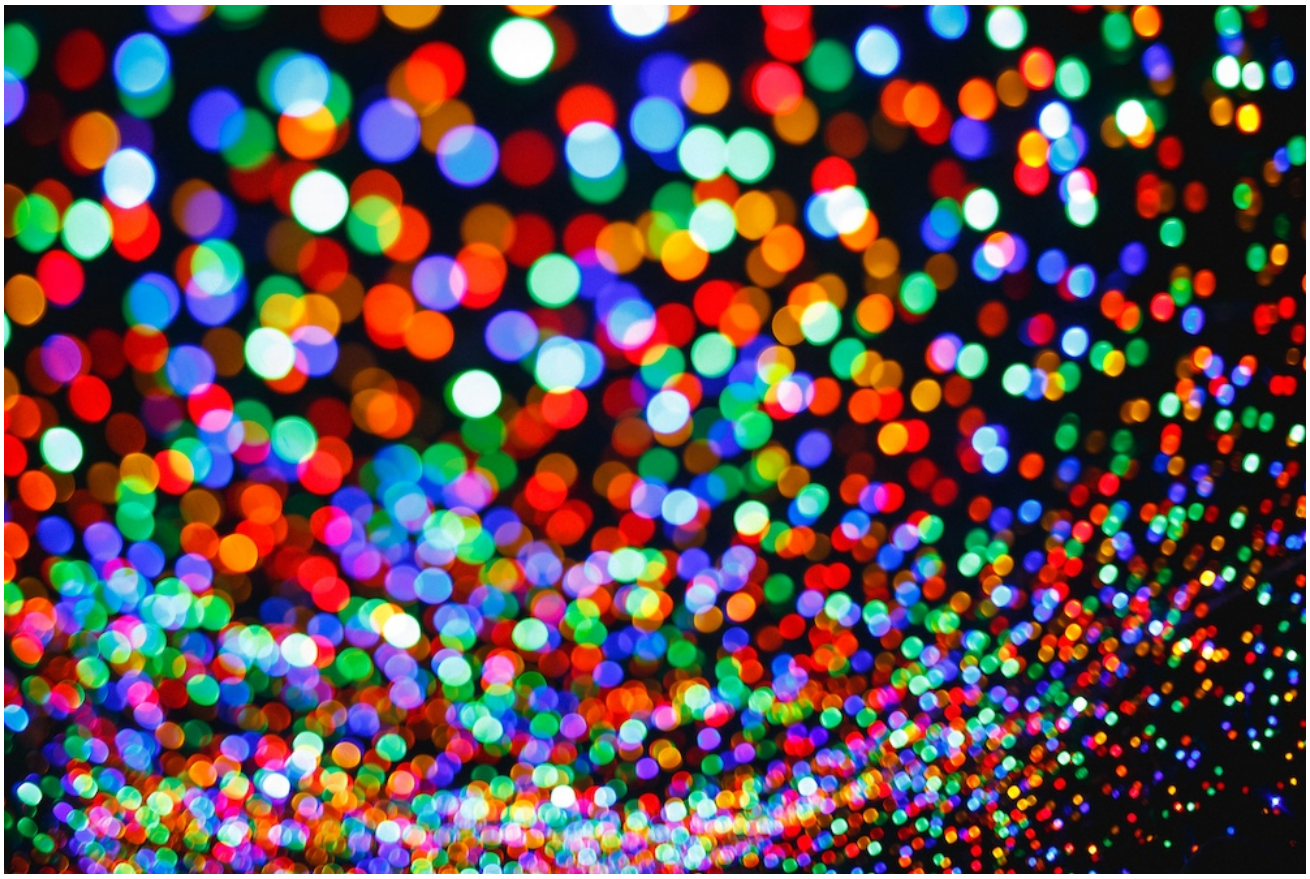
Image: Amber

How Your ACO Can Optimize APP Reporting Using Medicare CQMs

written by Roji Health Intelligence | August 22, 2024



ACOs just gained a reprieve from implementing all-patient APP quality reporting in 2024. A provision in CMS's Physician Fee

Schedule Final Rule, which goes into effect on January 1, 2024, enables ACOs to report on Medicare patients only, based on CMS provision of eligible patient lists for three APP measures. If your ACO decides to delay aggregation of practice data for now, you need to consider how to optimize APP Reporting of Medicare CQMs.

Choose a qualified registry for APP Reporting that can reduce your workload for reporting Medicare CQM Measures.

Using CMS's list of patients eligible for measures will mean that your ACO will not need to aggregate data to determine who is eligible ("denominator" data). But make no mistake. Gathering measure responses ("numerator" data) from across your provider network will still require work from ACO staff.

Unless you make strategic choices, understand that using Medicare CQMs will redeploy your staff from existing ACO activities to pulling data for APP measures for part of the year. Choosing a qualified reporting registry will help to streamline this work. So will your choice of which measures to devote resources to. Patient volume is largest for those eligible for depression screening and those with hypertension.

Specifically, of the three APP Reporting Measures for Medicare CQMs, here's what to expect:

- Screening for clinical depression (all Medicare patients with an annual visit);
- Blood pressure control for patients with hypertension (up to 50 percent of Medicare patients);

Hemoglobin A1c control for patients with diabetes (up to 35 percent of Medicare patients).

Depending on the size of your ACO, the number of patients could be very large and require a lot of staff time.

Tip 1: Your registry must be able to aggregate flat files of numerator data when feasible.

That allows you to spend less ACO or practice staff-time gathering data. An experienced data aggregator should be able to collect data for Medicare CQMs from most systems for a much lower cost. Another bonus: the registry will also be able to align patient-centric data so that you're reporting the most recent value for the measure, as required by CMS.

Tip 2: Your qualified registry vendor must have an interface to allow direct input of measure data that cannot be aggregated.

The interface should have all the required information—including date—to ensure the correct value is reported. Roji Health Intelligence allows for individual patient data entry through a secure online portal, with immediate update of your measure results.

Choose a qualified reporting registry with a long-term advantage.

Without a plan for data aggregation, your ACO will struggle to compete with organizations that have data-driven strategies for controlling costs and improving outcomes and health equity, because improving savings returns more to clinicians and patients. Consider that you will eventually need to aggregate data, and use this time to plan for it. CMS strategies for all-payer ACOs, along with the Rule's provision that ACOs require

certified EHRs in ACO practices, all point to Medicare CQMs as a temporary solution.

A trusted and qualified CMS-approved registry can facilitate data processing and submission of performance measures. Choose a registry that has the breadth of experience in aggregating data in multiple formats, has a track record with CMS, and offers personal service.

Over 11 years, Roji Health Intelligence has built a proven record of quality reporting for CMS, aggregating data from all certified EHRs in all formats. If you are aggregating data from all sources, your registry should enable you to see the status of your patients throughout the year—regardless of whether they are Medicare-only or all patients. Your patient measure results should be patient-centric; collection of measure data by any eligible practitioner will be attached to the patient.

Tip 3: Ensure that your registry is willing to help you organize your implementation and is vested in your results.

Talk to references and make sure that you aren't buying software or a simple interface, and that the team has proven expertise and is committed to results.

Tip 4: Look for other features to improve your ACO results, in areas of cost control and outcomes improvement.

Your data should work hard for you to create opportunities. Once you are aggregating data, you can use it to create strategies to improve your patient outcomes, reduce cost variation, and target your population health activities. Roji Health Intelligence uses episodes of care to compare costs and services for patients in both chronic disease and specialty care, and to target interventions based on priority.

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Image: Katya Ross