

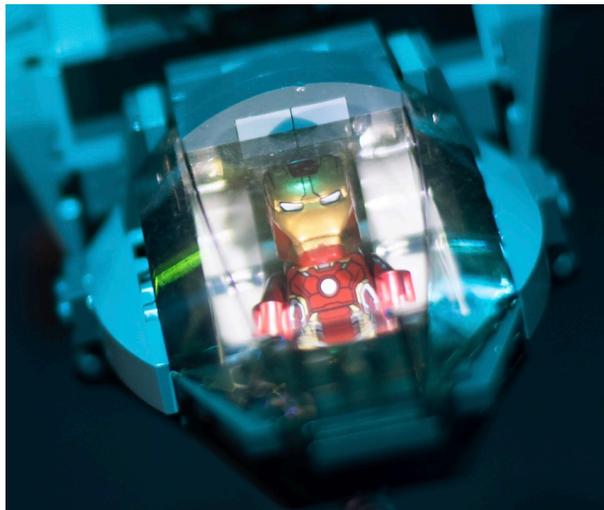


Ultimate Guide to APP Reporting for ACOs

ROJI Health Intelligence Ultimate Guide to APP Reporting for ACOs

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Introduction

There's a tectonic plate shift underway in ACO quality reporting. After several years of delays to appease ACOs requesting preparation time, CMS finalized new requirements. The [2023 CMS Physician Fee Schedule Final Rule](#) stipulates that APMs must report through the Alternate Payment Model Performance Pathway (APP), beginning with performance year 2025. Significantly, the APP requires reporting on *all* patients, rather than a small subset of only Traditional Medicare patients. No longer will a sample of 248 Medicare patients be enough for your ACO to demonstrate the provision of high quality and equitable care to patients.

In finalizing the Rule, CMS codified principles to fulfill the goals outlined in the [Innovation Center Strategy Refresh](#) of October 2021. The agency committed that, by 2030, all Traditional Medicare beneficiaries will participate in accountable care relationships that also ensure equitable health care.

CMS will push health equity by requiring ACOs to report quality measures through the APP, which requires measures of a broad base of patients whose needed services are often not received due to financial reasons and other obstacles to access.

Why is the APP such a huge shakeup for ACOs? For ten years, ACOs could canvas quality results for a small population of patients, small enough for nurses to pull information from medical charts to submit through the CMS Web Interface. Now, however, by requiring reporting on all patients, including non-Medicare, ACOs will need to aggregate data for their entire patient base. That requires technology not only for data aggregation, but also for quality performance measurement infrastructure.

Many ACOs may not understand how to meet CMS measure specifications through an aggregated data process, nor have the technology in place to do it. Unfortunately, some ACOs lost the lead time for implementation, believing that CMS would relent and further delay the APP. The time is now to catch up and prepare for the quality reporting transition.

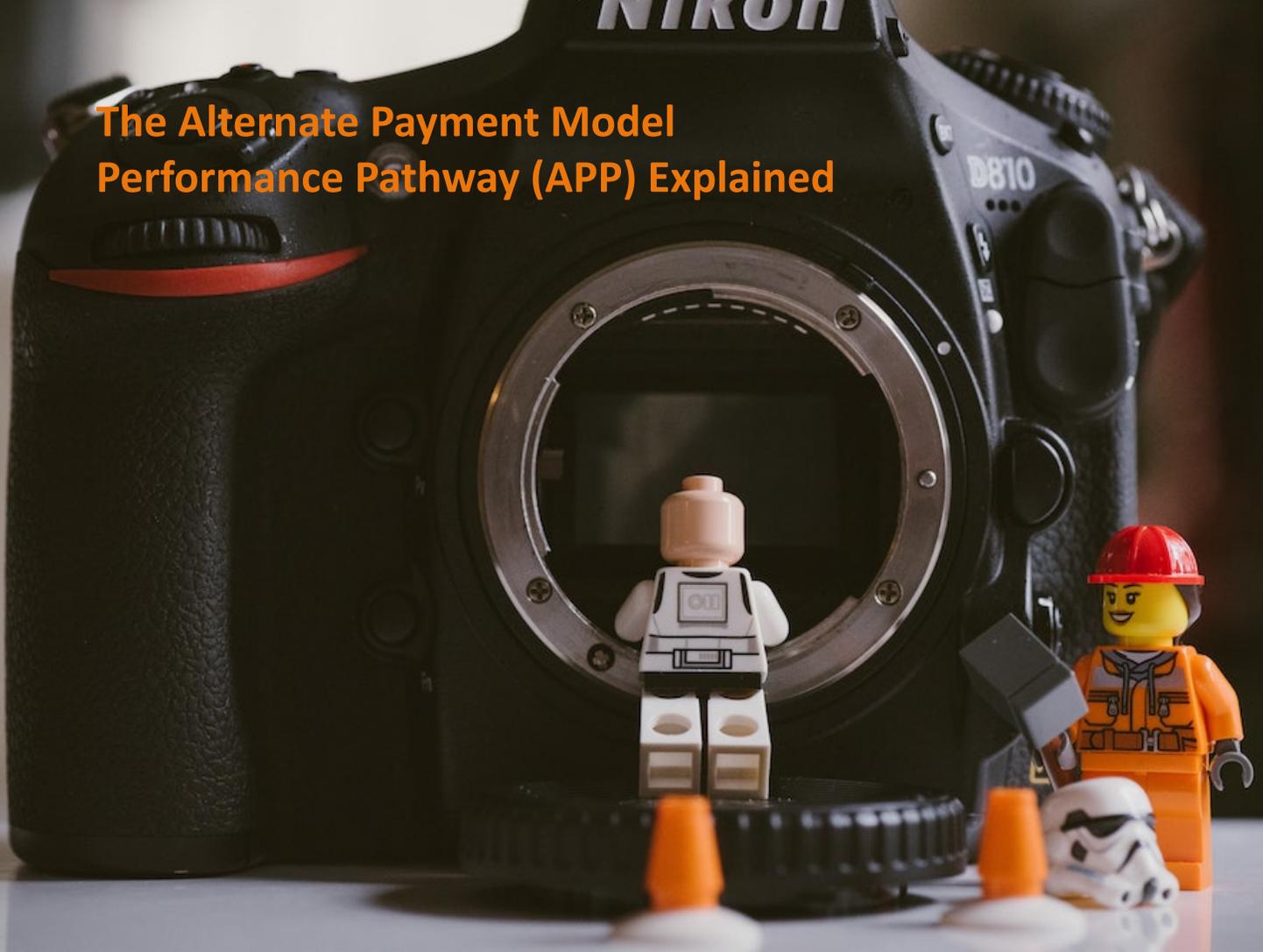
In this guide, you'll gain the knowledge base necessary to adopt APP reporting and discover best practices for your organization to achieve success. What you'll learn:

- The mechanics of all-patient reporting and how to fulfill measure requirements for patients;
- Obstacles to implementing APP and how to overcome them without delay;
- Fundamentals of data aggregation for quality reporting, and where you can get needed expertise;
- Pitfalls in data sufficiency that could lower your success under the APP, and how to fix them; and
- Strategic use of quality reporting data in ACO improvement programs.

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The Alternate Payment Model Performance Pathway (APP) Explained



What is APP Reporting?

The APP is a method of reporting quality measures for APMs, including ACOs. There are three key points that underly the transition to APP:

1. The APP brings ACO reporting in line with how other providers report under the Merit Incentive Program (MIPS—reporting quality measures for all patients who received services).
2. The quality measures themselves are MIPS measures.
3. By including the entire ACO population, the APP provides a vehicle to more accurately measure quality performance as well as health equity.

CMS has attempted to entice ACOs to report electronic clinical quality measures (eCQMs) or MIPS Clinical Quality Measures (MIPS CQMs) through the APP. However, these efforts have been largely unsuccessful. As of 2021, only 12 ACOs opted to report eCQMs/CQMs instead of the Web Interface measures.

The CMS Web Interface sunsets after the 2024 performance year, so you have a maximum of two more performance years to transition to APP 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.*

Three Measures Under the APP

In APP Reporting, ACOs will report on fewer measures than the current method. The CMS Web Interface "sample method" requires reporting data for 10 CMS Web Interface Measures. Under the APP, you will only need to report three MIPS/CQM measures. Three more measures will be calculated for ACOs, including two CMS-calculated measures and the CAPHS patient survey of patient experience. You have the option to continue to report the 10 CMS Web Interface measures until performance year 2025 (as well as APP measures, if you wish), and CMS will accept the highest results.

The APP measures focus on several areas that drive costs: diabetes control, depression screening, and hypertension. These are remarkable because all three measures are markers for both improvement in patient outcomes and provision of health equity.

The three MIPS/CQM Measures in the APP are as follows:

- Diabetes Hemoglobin A1C Poor control (>9%) (Measure #1)
- Preventive Care and Screening: Screening for Depression and Follow-up Plan (Measure #134)
- Controlling High Blood Pressure (Measure #236)

Connection Between Health Equity and the APP

CMS states that health equity is one of the six strategic pillars of CMS programs nationwide, including Medicare, Medicaid, CHIP, and the government's Health Insurance Marketplace. The [Health Equity Data White Paper](#) published by CMS in November 2022 asserts that the lack of complete and standardized socio-economic data stymies progress on reducing health disparities. Lacking the authority to collect such data itself, the agency pledges to use its programs to facilitate the generation of sufficient data to evaluate equity among patient cohorts.

The APP is a vehicle by which your ACO could vastly improve the volume and depth of data available to improve care. Aggregated data is essential to identifying patients with needs or not meeting the standard of care. When rich in detail, data provides the pathway to connect patients with necessary social and financial services, thus raising the standard of care available to them. This is exactly what CMS had in mind when it introduced the ACO REACH payment model and tied the concepts of accountable care with provision of equitable access and services.

ACOs that have resisted the APP because it raised the bar for data collection will need to reevaluate their positions. CMS and private payers will exert more pressure on ACOs to insist on better data collection from ACO participating providers in order to support targeted strategies in health equity, outcomes improvement, and cost control. The option for ACOs to be "low-tech" organizations that try to coordinate care based on retroactive claims data is disappearing. You will need to embrace the opportunity to insist that providers participate in data aggregation or become irrelevant to Value-Based Care.

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Two Significant APP Challenges for ACOs



Challenge 1: Differences in Measure Calculations Under Aggregated Data

One major reason for the slow adoption of APP reporting is that ACOs comprised of multiple practices (with different EHRs), do not have the means or [expertise to aggregate data](#) and track a unique patient throughout the ACO, for quality reporting purposes. Nor can they easily identify the latest triggering event for reporting the most recent value of a measure, as required by several measures.

While CMS claims data identifies unique patients, it only includes Medicare patients, and so the remainder of patients do not appear in the Medicare data, as required by the APP. Furthermore, the data required to identify lab values such as Hemoglobin A1C or blood pressure is practice-specific, whereas the reporting is patient-specific. Integrating that data across all practices is required in order to identify the most recent episode of blood pressure readings or tests wherever the patient was seen. Your ACO must overcome three major technology hurdles for APP Reporting:

1. **Aggregation of all practices' data** so that the entire population of patients and their conditions contribute to the denominator of APP measures

2. **Patient-matching algorithms** that identify unique patients across practices so that patients are not duplicated, and the latest values of measures can be identified;
3. **Measures engine** that correctly calculates the denominators and numerators associated with the measure for each patient.

Failure to overcome these obstacles precludes accurate numerator and denominator calculations, as measures apply at the patient level (not the patient-practice level) and may require the most recent value. If you cannot track patients across the network, you cannot report through the APP.

Challenge 2: Quality of Practice Data Is Untested

By including all patients in APP Reporting, performance may suffer for ACOs with large underserved populations. Social Determinants of Health and income inequality play a significant role in poor outcomes for [patients with chronic disease](#), so you may see performance rates drop when reporting globally. This is the polar opposite of CMS's intended goal of integrating health equity with accountability for ACOs. As a result, CMS created several provisions in the recent Rule to counteract this, the first of which is to incentivize ACOs to report through the APP, and to make it happen prior to the 2025 requirement.

Your ACO will need the lead time to test the effect of APP Reporting on your public scores and take preemptive action to implement improvement strategies. This includes addressing not only the overall performance results of measures, but also working with practices to improve SDOH collection on the front end, so that patients can be targeted in population health solutions before they impact ACO quality scores.

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CMS Incentives for ACOs to Adopt APP Reporting



CMS has addressed APP reporting concerns in several ways. In particular, the agency has eased performance requirements for those reporting eQMs/CQMs for all patients.

Eased Performance Standards for Next Two Years

In 2023, if your ACO meets the data completion threshold (70 percent of eligible patients, just like in MIPS), then your quality performance score only needs to equate to the 10th percentile of the performance benchmark for one of the outcome measures, and the 30th percentile for the others. CMS Web Interface reporters are held to a higher standard, needing to achieve a score at or above the 30th percentile in all categories.

In 2024, you will need to achieve the 40th percentile on the other measures, but the outcome measure will still only require performance at the 10th percentile. Those reporting via the Web Interface must meet a higher standard, as well, achieving a score equivalent to the 40th percentile in all categories. Once eQMs/CQMs reporting becomes mandatory (beginning in 2025), your ACO must report via the APP and achieve the 40th percentile in all measures to earn the maximum rate of shared savings.

In addition to these eased performance standards in 2023 and 2024, ACOs that report the all-patient measures and that serve a high rate of underserved patients may receive a Health Equity Adjustment consisting of up to 10 points towards their Quality Score. To further sweeten the deal, CMS is instating a sliding scale approach for quality performance. Rather than the previous “all-or-nothing” approach, you will still be able to share some savings, even if your quality performance is lacking.

Extension of APM Lump Sum Payments Encourage ACO Participation and Increase Competition

One hitch that CMS had encountered in transitioning people into APMs is that the final 5 percent lump-sum APM payment incentive is being paid in 2024, based on 2022 performance. However, at the end of the year, Congress passed the [Consolidated Appropriations Act of 2023](#), which extends the lump sum payment for participating in an APM, including ACOs.

The Final Rule also indicates that there will be a conversion factor applied to APM Qualified Participants (QPs), meaning that ACOs have a greater opportunity to eclipse the incentives participants would earn on their own if they broke off from the ACO. The upshot is that existing ACOs will continue to face competition from existing ACOs that choose to remain in the program, combined with newly formed ACOs that may have otherwise chosen to wait until CMS addressed the APM incentive payments in 2024. With the existing ACO pool likely to expand, and new ACOs more likely to have an APP plan in place from the start, existing ACOs who are not primed to succeed in APP reporting can expect to come up short when compared to their peers.

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A Step-By-Step Path to APP Reporting Success



Now that we have established that the APP is both feasible and advantageous, it's time to develop a practical, step-by-step approach that prepares your ACO for APP reporting and capitalizes on your success. Your goal is to earn a quality score that ensures maximum shared savings, and to leverage your efforts into more efficient and proactive patient care. Here's how to do it:

1. Get the expertise and infrastructure you need for All-Patient Reporting under the APP.

The fastest and most cost-effective way to ensure that your ACO's data is aggregated correctly and prepared for measurement is to use a CMS-authorized registry for reporting—more specifically, an Advanced Clinical Data Registry, with established [expertise in data aggregation and reporting](#).

Here's what to look for:

- **Experience in aggregating data from many different EHRs**, using customized multiple data formats for data collection, and integrating that multi-practice data into a single ACO database for APP reporting. True data aggregation is a must-have, as simply adding the results from each of your practices' QRDA I (patient-level) or QRDA III (aggregate) files will not produce valid results. The APP measures must be reported at the ACO level, meaning that if a patient has triggered a measure at

multiple practices, then that patient should only be counted in the denominator once using the most recent value.

- **Experience matching patient records across groups, even when practices use different EHRs and do not share a common Medical Record Number.** This enables you to track a patient across the continuum of care. It is almost inevitable that a patient would become eligible for a measure at multiple practices. Even though the measures have a primary care focus, the denominators do not account for specialty. So, a patient may become eligible for the Hemoglobin A1C Poor Control measure (Quality ID 001) based on an encounter with their primary care provider. However, if that same patient sees, for example, an orthopedic surgeon in the office for a footwear evaluation, that is also a denominator-eligible encounter. The measure requires that the patient is measured singularly, across the ACO; an ACO that simply adds practice results will be creating artificially inflated denominators and invalid results.
- **Capability to use the data to create analytics on cost and quality,** implement cost performance strategies, tie into your population health activities, improve specialty care, and conduct other major projects your ACO is undertaking to improve your position. A reporting-only registry may be what you need for now, but you need to be able to achieve maximum value from your data to make your ACO successful.
- **These three requirements will be satisfied by the use of a top tier, [ONC-certified Clinical Data Registry](#)** qualified by CMS to report either the electronic version of APP Clinical Quality Measures (eCQMs) or their MIPS CQM counterparts directly to CMS. Your ability to include a variety of practice types and technologies in APP reporting may require the use of MIPS CQMs in reporting, so this flexibility is optimal.

2. Identify all EHRs and other systems, and confirm data export capabilities.

It's important to do the background work now to prepare for data aggregation. What you don't know about your practices' systems will delay the process of data aggregation. This step is crucial and best performed by the ACO itself because, first, it would be more expensive to use outside expertise for this step, and second, your ACO needs to understand and trust the results of your EHR/practice management survey. Regardless of whether your practices all use the latest ONC-certified versions of their products, or whether their systems do not meet minimum Promoting Interoperability requirements, your chosen vendor can help you develop the specific questions and requirements.

Basic information that must be known about all practice systems include:

- Name of vendor
- Type of system

- Latest version of system/upgrade version
- Whether lab reports and other clinical data are integrated into system
- Export capabilities for HL7, FHIR, QRDAs, and reports
- Whether SDOH data is collected by the practice
- Who technically manages the system for the practice (internal/external)
- Practice/data contacts

Be specific when gathering this information. Hearing that everyone can export QRDAs is good, but it is not enough—you need to confirm the file type and the data that their systems populate in the QRDA itself.

There are two types of QRDA files: QRDA I files and QRDA IIIs. QRDA I files contain individual patient results, while QRDA IIIs are high-level results for the group. When aggregating all practices' patients, it is critical to recognize that QRDA III files are NOT sufficient. They show the number of patients eligible, and performance calculations. They do not give you the ability to see individual patient details, and therefore, cannot be used to establish your ACO's true measure denominator.

Should you have practices that cannot export QRDA I files, or even do not have an ONC-certified EHR (or even a practice that is still documenting on paper charts!), don't fret. With an Advanced Clinical Data Registry, there are additional options for data aggregation. Using a combination of QRDA Is, ad hoc reports, and even spreadsheets, if necessary, your data aggregation partner can weave together a complete picture of your ACO.

3. Select your reporting method—is intervention required?

There are two options for APP Reporting: Electronic Clinical Quality Measures (eCQMs) and MIPS Clinical Quality Measures (MIPS CQMs). Both types require all patients, and the three measures in each type track the same information.

The difference is that eCQMs are calculated by the EHR itself—it scoops up all of the results from a pre-defined set of fields and packages them into a QRDA I file. The files contain eligible patients and how the ACO fared in each instance. On the other hand, MIPS CQMs may incorporate other information into the measure numerators.

MIPS CQMs can be advantageous, as providers' workflows may result in measure responses saved in a location that the EHR does not harvest when creating QRDAs. Your Advanced Clinical Data Registry can import those values and integrate them into your results. You'll find this to be invaluable, as the disconnect between the EHR's intent and a user's workflow is already [hit-or-miss](#); when factoring different users at different sites on different systems, this issue can metastasize exponentially. Without a

partner, you'll have more records to abstract than available time, and you will not be able to meet minimum performance thresholds.

If your ACO's EHR pool includes systems that either do not have the capability of exporting QRDA I files, or there is too much variability in user workflows to meet data completion thresholds, your choice has already been made: you must go the MIPS CQM route. If everyone has high quality QRDA I files, you have the option of reporting the eQMs. It is easier, but you are locked into what's picked up in the creation of the QRDA I file, so buyer beware!

4. Leverage APP success to improve population health.

After you have gathered valuable data, you'll see that quality reporting is just the beginning of what you can accomplish. Make that data work for you to improve outcomes and cost performance. You now have the ability to see what is potentially behind poor outcomes, be it an absence of care, network leakage, or therapeutic inertia for patients with chronic conditions. Here's how to do it:

- **Transform quality issues into improvements.** Start with the quality measures themselves. They should not be stand-alone items on a reporting list, but should pave the way for further investigation and interventions. If your patients have high blood pressure and/or hemoglobin A1C, or who have not been screened for depression, it is critical to understand the cause. If you have providers whose patients have higher blood pressures than their cohorts, investigate the cause. Blood pressure is frequently improperly taken—no advance rest, dangling feet, no back support, talking to the patient—and can produce artificially high blood pressure readings. Those results will distract you from the patients that do need additional attention.
- **Identify patients with persistently poorly controlled intermediate outcomes for potential intervention.** These patients are more likely to require emergency or inpatient care. [Understanding the reason](#) behind the persistent poor control enables you to be proactive, giving you actionable data to pro-actively prevent a poor outcome, rather than having to address it after the fact. The benefits multiply—as your performance improves, so does your patients' health, meaning that you are simultaneously succeeding in both cost and quality.
- **Use your data to branch out into other areas of improvement.** For example:
 - Examine whether procedural episodic costs vary by practice, provider, or facility.
 - Investigate the root causes of persistent poor control in other chronic conditions, and intervene.
 - Understand your population's Social Determinants of Health (SDOH) needs, and address barriers to treatment.
 - Demonstrate a single high standard of care by participating in value-based care initiatives with private health plans.

Reporting through the APP is not the daunting task that it first appears. Your ability to identify unique patients across your network gives you the ability to have a greater positive impact on your population and community as you address costs and quality. Deferring the decision to integrate your organization's disparate data sources will only keep your organization at the starting line in the race to Value-Based Care, even as others are making the first turn. Use an efficient, data-driven approach to take control of your own future, and demonstrate your ability to deliver exceptional care.

Image: [Daniel K Cheung](#)

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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.

