Customize Your APP Approach:

How a Low-Cost Solution Today Can Drive Innovation Tomorrow

Dave Halpert

Roji Health Intelligence LLC

Chief of Client Team

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This presentation is for:

- Health systems and medical organizations participating, or considering participating in ACOs, specifically:
  - ACO Board Members
  - Hospital and Medical Organization Administrators
  - Quality and Compliance Officers
  - Information Technology Specialists

Today's Track

- How the APP differs from the CMS Web Interface
- Requirements for APP Reporting
- The benefits and pitfalls of the APP reporting options
- Choosing the APP option for you
- Effectively preparing for the APP
- Making the most of your resources
- What to expect from your Qualified Registry
- 10 metrics for data-driven quality reporting

Audience Poll

“Tank” you for your feedback!

Which of these best describes your APM Performance Pathway (APP) strategy?

About Roji Health Intelligence

- We provide Value-Based Care technology and services to improve outcomes, cost performance, and equitable health care.
- Our powerful tools identify patients with persistently poor or high-risk outcomes and target health interventions.
- We provide our clients with the ability to engage physicians and other clinicians on meaningful, clinical improvement for patients.

What is the APP?

- A quality reporting method for APMs (Alternative Payment Models)
- APMs are risk-based reimbursement models, like ACOs
- APM Performance Pathway = APP
- The Purpose: Ensure quality is measured for <u>all</u> patients (eventually!)

The Reasons Behind the APP Transition

- Aligns ACO reporting with with Merit-Based Incentive Payment System (MIPS) reporting
- Measurement consistency, as APP measures are also used in MIPS
- Including a greater proportion of the population more accurately measures performance, and illuminates health equity disparities

The APP is A New Ball Game!
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Measures in the APP

- Active reporting is required for 3 measures:
  - Diabetes Hemoglobin A1C Poor control (>9%) (Quality ID 001)
  - Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID 134)
  - Controlling High Blood Pressure (Quality ID 236)
- Measures Calculated by CMS and Survey Vendors
  - CAHPS Patient Experience Survey
  - Hospital-Wide 30-Day, All Cause Unplanned Readmission Rate
  - Risk-Standardized Admissions for Patients with Chronic Conditions

3 Options to Report the Same Measures

- Electronic Clinical Quality Measures (eCQMs)
- MIPS Clinical Quality Measures (MIPS CQMs)
- Medicare Clinical Quality Measures (Medicare CQMs)

How Do Reporting Options Compare?

Measure Type	Eligible Patients	Allows Manual Intervention	Denominator Calculation
Medicare CQMs	Medicare Only	Yes	CMS
MIPS CQMs	All	Yes	Third-Party Intermediary
eCQMs	All	No	Third-Party Intermediary

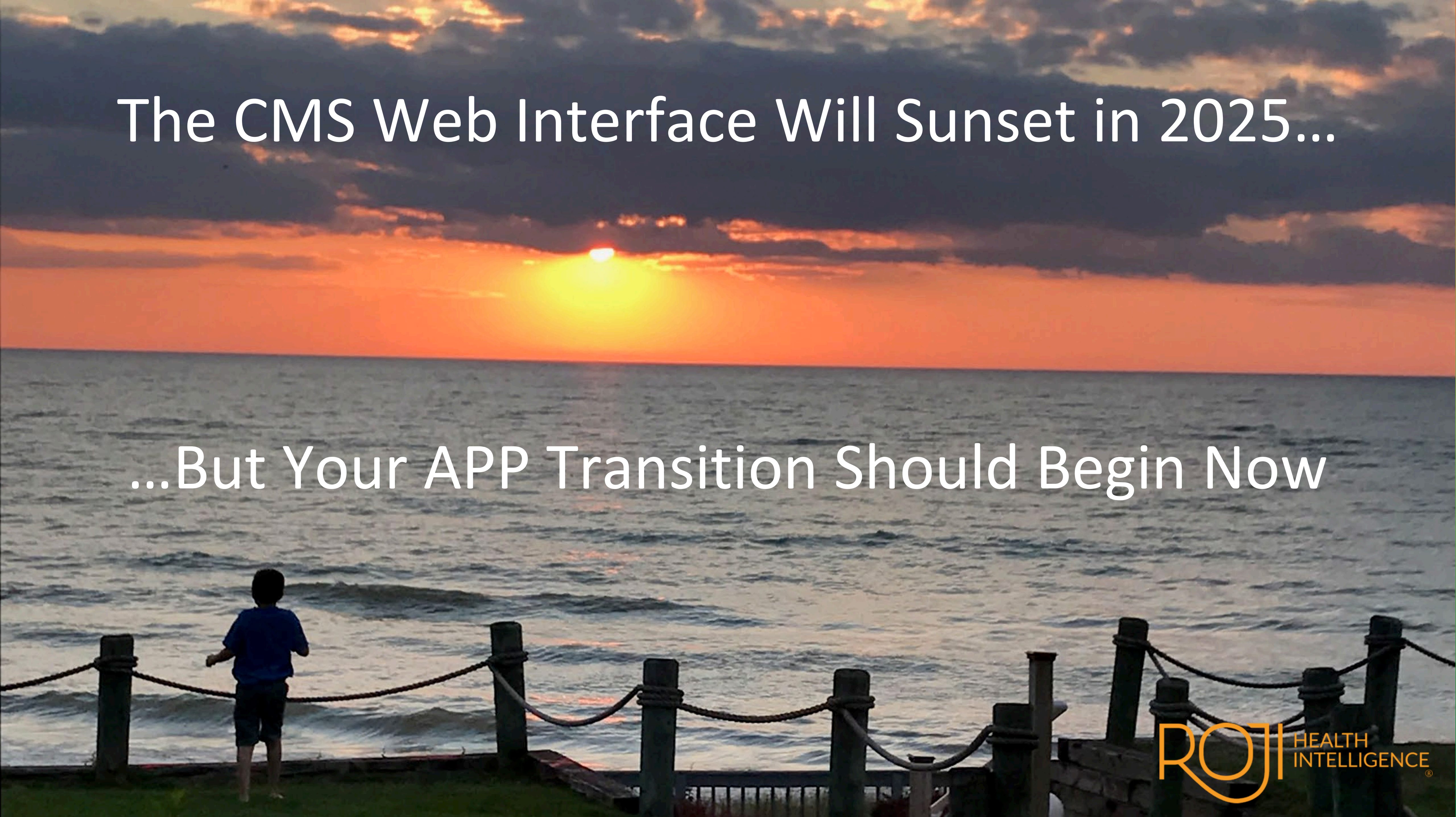
“All” Patients is Not Hyperbole

Pandamonium (n.): The appearance of chaos, but with a Panda

- Eventual standard: All patients, regardless of coverage (public, private, out-of-pocket)
- Quality reporting denominator shifts from a maximum of 248 instances per measure to ????
- Requires aggregation of data from each EHR

The Medicare CQM Stepping Stone

- CMS identifies eligible patients in their quarterly uploads – avoids need for data aggregation in small ACOs
- For larger ACOs, patient numbers are too big to manually abstract numerators for reporting – but a vendor who can customize a targeted data aggregation approach has an effective solution for APP Reporting
- Delayed denominator-eligible patient lists make improvement challenging – final quarter delivered in February of the next year (mid-Submission Period)
- Allow for more cost-effective (but less comprehensive) data aggregation processes
- Qualified Third-Party Intermediaries submit results through the CMS QPP submission API


The CMS Web Interface Will Sunset in 2025…
…But Your APP Transition Should Begin Now
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ACOs' Big Fears of All APP Reporting Methods

- Too many patients to manually compile numerator values for measures
- Too expensive/problematic to aggregate data to report all patients
- Administrative burdens for providers and staff
- Performance implications for ACOs with underserved populations

APP Incentives

- Health Equity Adjustment for ACOs with underserved populations
  - Up to 10 Quality Points, based on Dual Eligible and Area Deprivation Index rates

- Sliding Scale for Quality Performance
  - Not “All or Nothing” – can still share savings without hitting targets

The transition can be bear-able

Eased Performance Standards in 2024

	APP	CMS WI
Reporting Requirement	75% of eligible patients 3 measures	248 patients 10 measures
Performance Standard, Outcome	10th Percentile of Benchmark	40th Percentile of Benchmark
Performance Standard, Others	40th Percentile of Benchmark	40th Percentile of Benchmark

A Step-By-Step Path to APP Reporting Success
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Your Forward-Looking APP Strategy

Expertise Comes From Experience

- APP reporting infrastructure takes an ONC-Certified Clinical Data Registry with experience…
  - Reporting eCQMs and CQMs to CMS as a Qualified Third-Party Intermediary
  - Aggregating data from many different EHRs—a patient-centric database is a “must have”
  - Matching patient records across groups—without the benefit of a shared MRN
  - Using data to create analytics on cost and quality

Experience Must Include Customization

- No two organizations are identical
- Varying patient populations, organizational priorities, and technical resources
- The "Cookie-Cutter" approach only works on paper
- Experience sees cost-effective solutions that perform in the real world

Selecting the Right APP Reporting Option

- Medicare CQMs may have a limited population, but the denominator is slow to update. For larger ACOs, populating numerators is the big issue.

- MIPS CQMs offer flexibility and safety nets, but may require additional effort.

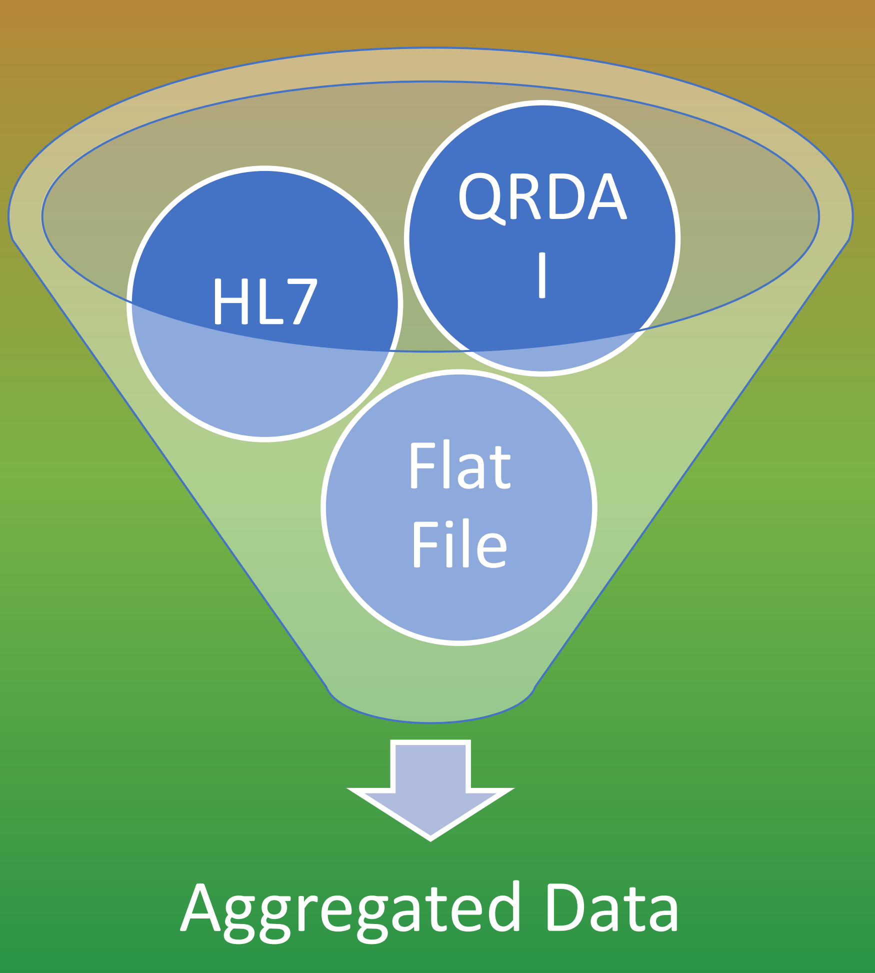
- eCQMs are automated, but carry risks

When to Utilize Medicare CQMs

- A stretched budget – Roji costs are less than 30 percent of a total data aggregation initiative
- Too many EHR unknowns – large systems maintaining disparate EHRs with uncertain capabilities
- Limited staffing – Identifying and addressing trends in the Medicare-only population is still helpful
- A short timeline – Startup is quick, and still qualifies for APP advantages

All-Patient Measures Require Data Aggregation

- Advanced Clinical Data Registries offer additional aggregation options
- Customized options are significantly less expensive than expected
- Patients are matched across disparate data sources
- Interface for direct entry
- APP "Reporting Ready," plus patient-centric insights



MIPS CQMs or eCQMs? Identify EHRs and Capabilities!

- Background work is critical for data aggregation – surprises equal delays
- For each system, you should know:
  - The basics: Name, Type, Version, ONC-Certification Status
  - Connectivity: Commercial lab interfaces, export capabilities
  - Workflow: Presence of custom templates, entry of SDOH
  - Administration: Who manages the system and who to contact

Use Roji TIPS (https://rojihealthintel.com/resources/tips) to prepare for data aggregation!

Beware: Adding EHR Scoring Produces Invalid Results

- Adding QRDA III files is NOT a solution
- Measures require the most recent result

- Example Patient Jon Doe
  - A1c on 1/17/24 at a practice using EHR 1
  - A1c on 2/28/24 at a practice using EHR 2
  - Correct value = A1c from 2/28/24 encounter

- Adding EHR 1 and EHR 2 counts Jon twice!

When to Utilize MIPS CQMs

- Variable documentation methods between practices and providers – you'll need several approaches
- EHRs cannot all generate QRDA I files – QRDA IIIs are summaries and cannot be aggregated
- Desire to support additional measures for quality efforts

When to Utilize eCQMs

- Quality reporting numerator collection processes are in sync with your providers' real-world workflows
- Provider education on documentation is comprehensive and there is provider buy-in
- All EHRs meet ONC standards and can readily produce QRDA I files

Every ACO is Unique! - Where Is Your Sweet Spot?

Medicare CQMs

MIPS CQMs

eCQMs

-Breadth of EHRs (or new set-ups)

-Value-Based Care Strategy Limited to Medicare patients

-Economic solution for a single purpose

Allows Customized Data Solutions

-Variable EHR Setup

-No VBC Strategy Limits

-All Patients

-Expanded Value-Based Care Possibilities

-Aggregated Data

-Single EHR or HIE Setup

-Harmonized Documentation

-Value-Based Care Strategy Limited to eCQMs

The Bottom Line

- You can do more with all-patient measures:
  - Leverage data aggregation to improve outcomes in other areas
  - Ensure that you have one high-level standard of care
  - Score measures for other specialties (including MIPS Value Pathways for Specialists)
- No reason not to start APP experience with Medicare CQMs:
  - You can blend data aggregation of bigger systems with manual abstraction to meet measure numerators
  - APP will help you identify high risk individuals for pop health
  - Participating in APP Reporting will give you greater rewards in early year

Use Your Investment to Create New Opportunities!

Leverage APP Success to Improve Population Health

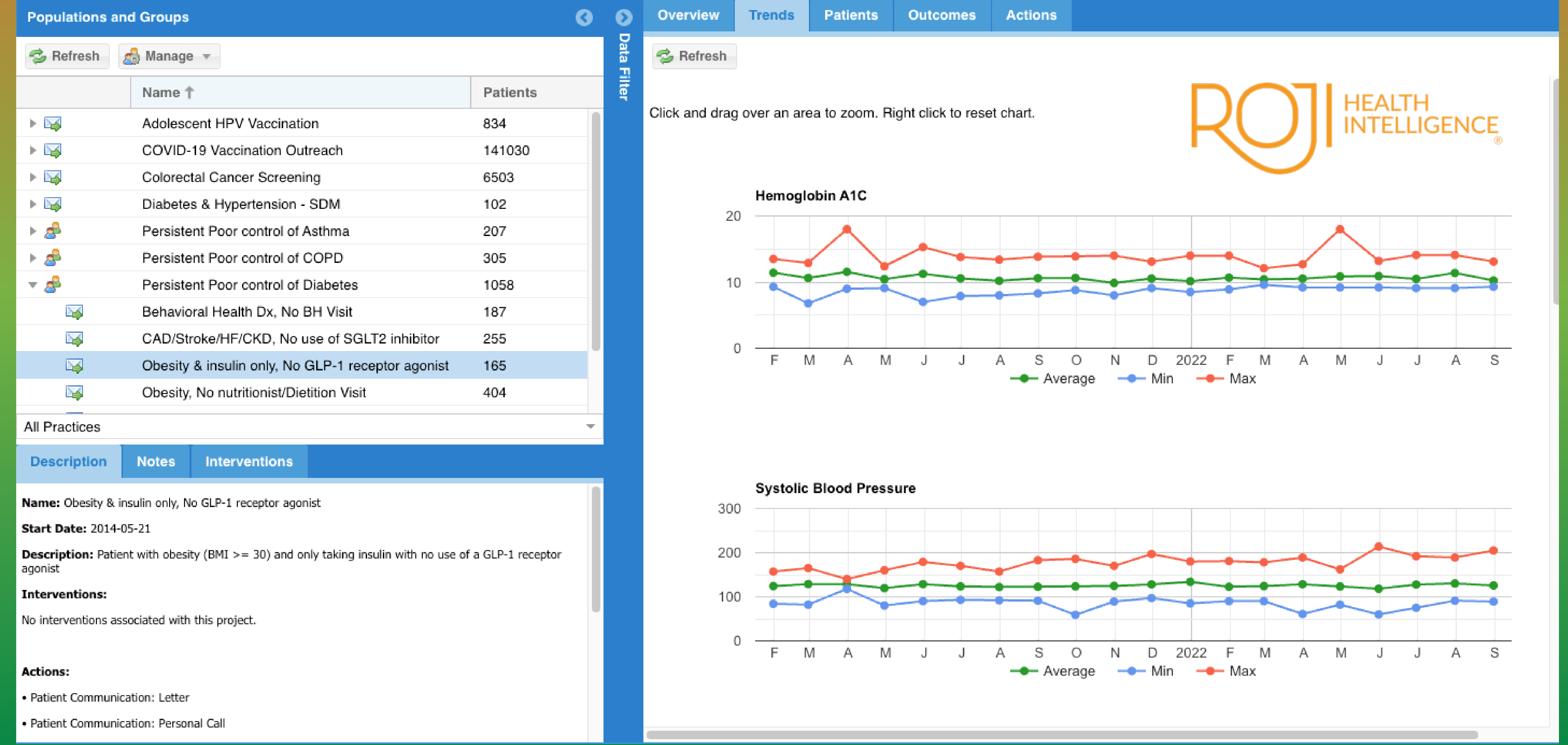
You did the heavy lifting – capitalize on your investment!

Quality reporting is the entry-level benefit to data aggregation

Start With the Quality Measures

- Performance shortfalls can illuminate opportunities
  - Are treatment plans changing for patients with high HGB A1c?
  - Are blood pressures really high, or are they taken improperly?
  - Does fewer depression screenings stem from lack of available in-network mental health care?

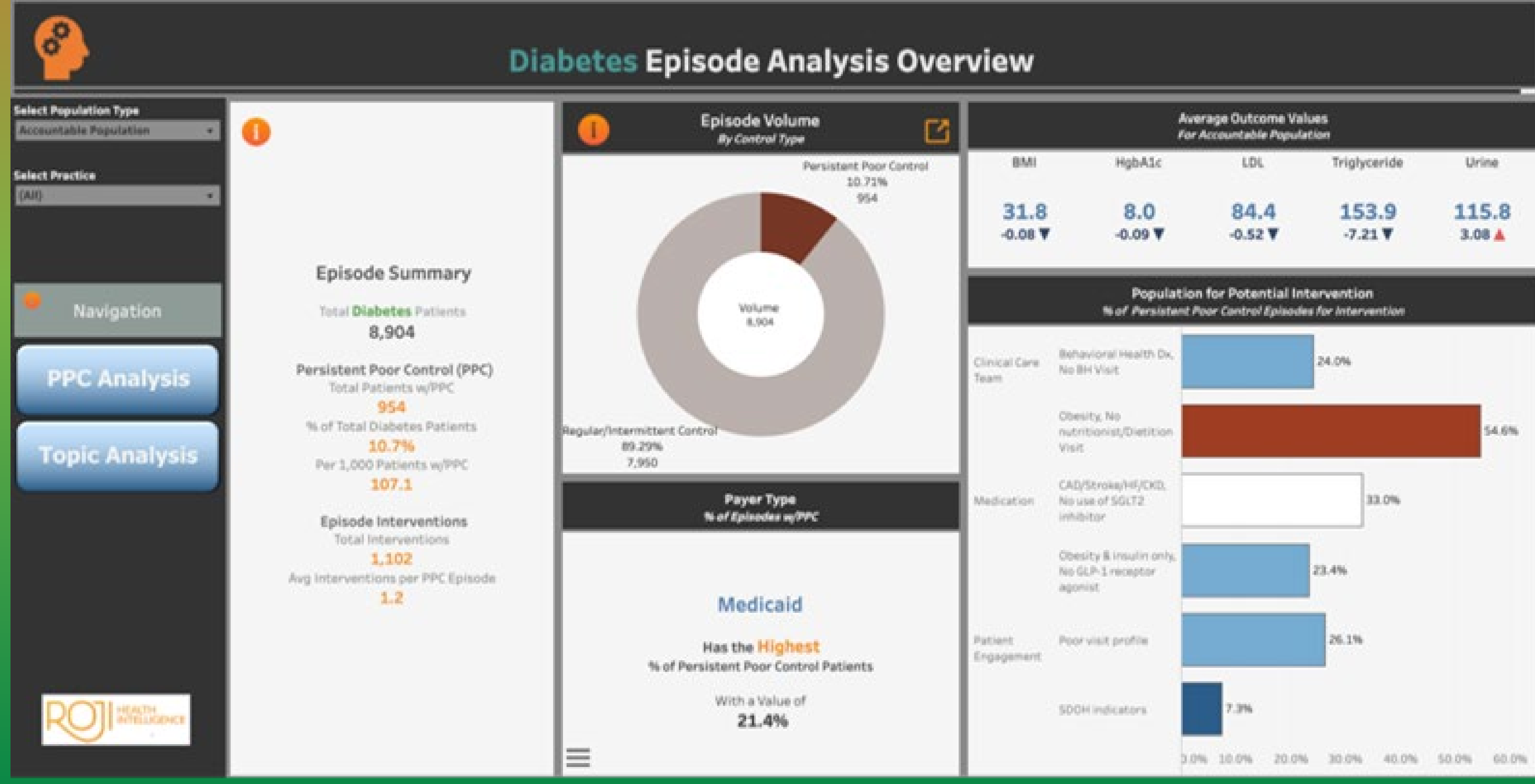
Transform QM Shortfalls Into Improvements



Graduate to Advanced Topics

- Identify patients with persistently poorly controlled intermediate outcomes for intervention
  - More likely to require emergency or inpatient care
  - Aggregated data is actionable – you can proactively intervene
  - Benefits multiply: As your patients’ outcomes improve, so does measure performance
- Is there variation between providers and sites?
- Branch Out!

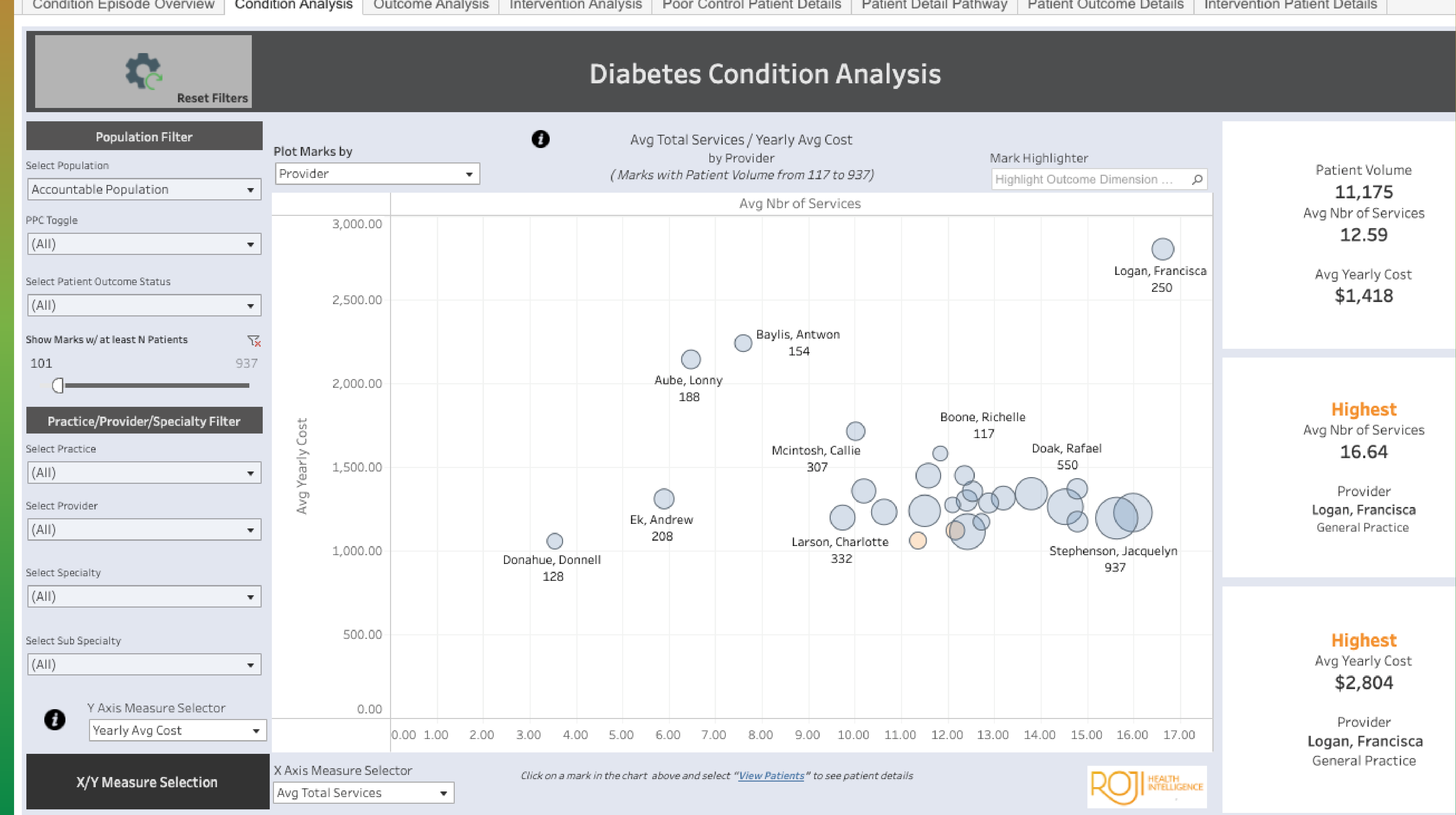
Data Aggregation Enables Proactive Population Health Interventions



Use Data To Branch Out

- Examine whether procedural episodic costs vary by provider or site
- Investigate the root causes of persistent poor control
- Understand your population's SDOH needs
- Demonstrate a single, high-standard of care by engaging private health plans in VBC initiatives

Comparing Intermediate Outcomes by Provider and Site



Comparing Procedural Costs By Provider and Site

Episode Cost by Provider for Cholecystectomy

Select Year: (All)
Select Episode: Cholecystectomy
Select Practice: Demo Practice - 5205
Select Specialty: (All)

Total Episodes	Total Cost	Average Cost	Episodes Above Average Cost	% Above Average Cost	Cumulative Cost Above Avg
532	$1,796,400	$3,377	204	38%	$496,756

Allen, Reuben
has the Highest cumulative costs over average
$174,668
Cholecystectomy

Cholecystectomy
Cumulative Costs and Percent of Episodes Above Average by Provider
(Click on a bubble to filter dashboard by Provider)

% Above: 80%, 60%, 40%, 38%, 20%, 0%
Cost Above: $0K, $20K, $40K, $60K, $80K, $100K, $120K, $140K, $160K, $180K; $62,095

% with Notable Observations

Provider	%
Brown, Sandra	19%
Duggan, Phillip	21%
Acevedo, Glenn	20%
Akers, Tara	19%
Brown, Samantha	25%
Allen, Reuben	35%
Amezquita, Dorothy	19%
Kenney, Jimmie	18%

Episodes: 0, 50, 100, 150

Episodes
NO Episode Vol

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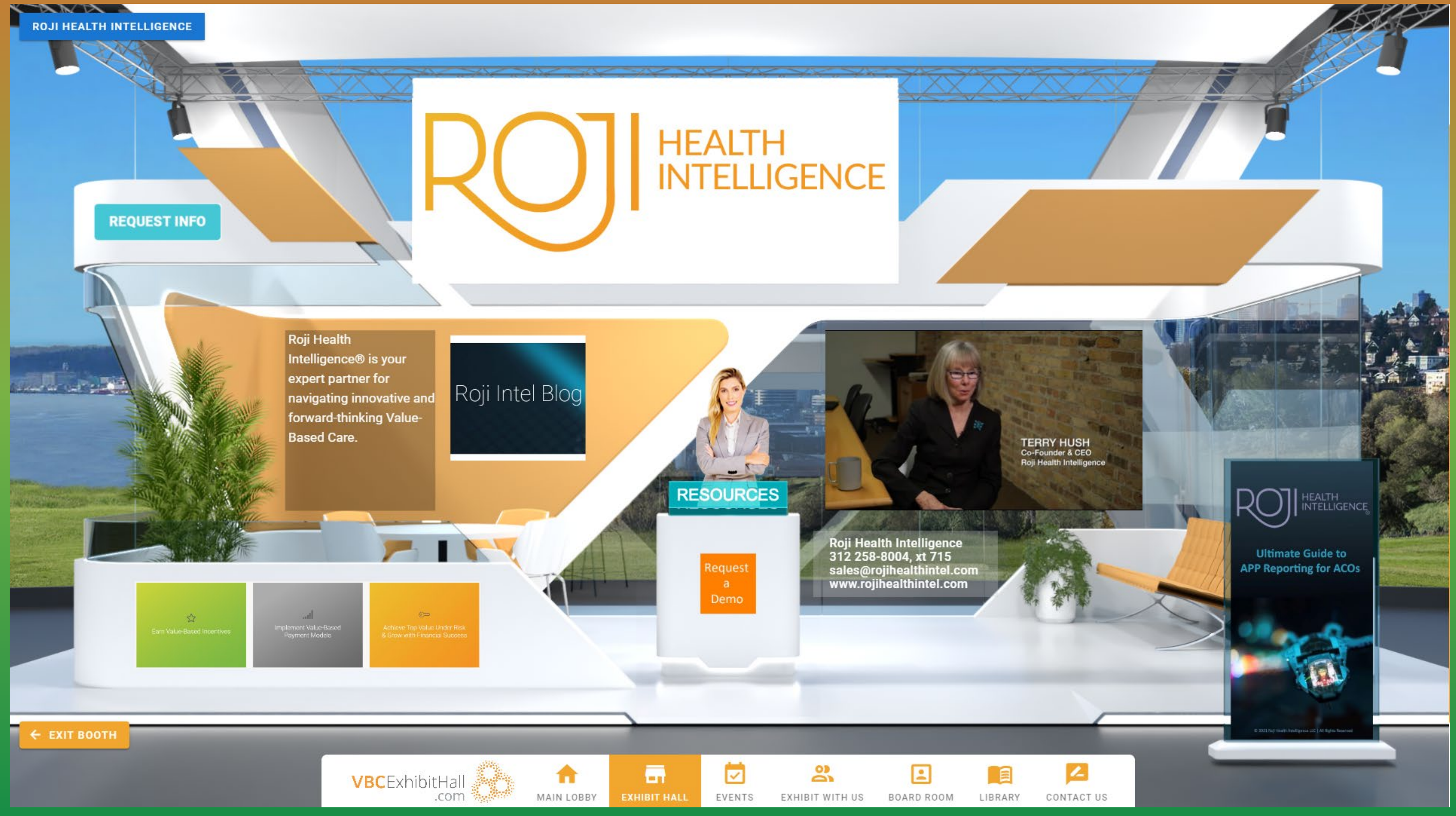
10 Metrics You Should Track for Data-Driven Quality

1. Growth in longitudinal clinical outcomes
2. Cost and outcome variations for conditions/procedures in practices and providers
3. Social Determinants of Health (SDOH) data from Data or NLP
4. Increased screening for chronic conditions and potential events
5. Percentage of providers in practice transformation
6. Provider buy-in to APP
7. Presence of defined outcomes for future improvement
8. Increase in implementation of interventions for patients with persistent poor control
9. Improved (and measurable) experiences for patients and caregivers
10. Demonstrable improvement over time

Questions and Answers

Stop by our VBC Exhibit Hall Virtual Booth



[Visit the Roji Heath Intelligence Booth]

Thank You

Contact us to make your transition to APP reporting successful!

Leonard Ho, Business Development, Roji Health Intelligence LLC
leonard.ho@rojihealthintel.com. (312) 258-8004 x715

Dave Halpert, Chief of the Client Team, Roji Health Intelligence LLC
dave.halpert@rojihealthintel.com

Roji Health Intelligence LLC
https://rojihealthintel.com
https://www.vbcexhibithall.com