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ASM Unpacked: What You Need to Know About CMS's New Mandatory Payment Model

Hello everyone, and welcome to today's webinar. ASM unpacked What you need to know about CM s s new mandatory payment model. Thanks so much for being here today with me. My name is Aaron Heilman, I'm the SVP of Regulatory Affairs here at Metasol, and I am excited to talk to you about this new mandatory ambulatory specialty model. I'll get into all the details behind that you should be seeing within your system here the PDF version of today's presentation. So be able to download that one and take a look at the slides. Follow along as we go or we'll be able to have it afterwards.

This session today is also being recorded as well, so you can come back and rewatch the session and get all your notes down from today's presentation. I hope to provide a bit of good information to you today. We are really going to be focusing on what CMS views as their cost and quality problem specialty today. Care today is optimized for moments not outcomes over time. So this is CM s s view care is episodic, it is reactive. The payment structure that CMS has put in place for these clinicians who are caring for Medicare beneficiaries reward volume of services, not prevention.

Quality measures focus on point in time performance and there is limited accountability for downstream utilization, total cost of care, long term patient outcomes. So I actually just got back from both HIMS and the CMS Quality conference and I will say that this has this exact theme was echoed multiple times in all of the CMS sessions that I went to. It's too expensive. It rewards more services. It is not about prevention and Wellness. And that it doesn't have this kind of longitudinal, longitudinal view of the patient health. They reiterated that same thing multiple times.

And so CMS believes that this ASM model is a step toward experimenting with a model that will hopefully make this change for them. So conceptually here's how CMS sees it before this ASM model, the clinician's approach and I'm looking at a low back pain example here. A clinician would engage when the patient is referred, they will focus on treating the visit or procedure. They'll there is variability in the use of conservative therapies such as like using PT before going for a surgery. Early imaging and escalation is more common. There's little limited follow up on patient progress and minimal accountability for downstream costs.

A patient experience in their view in the before ASM is that the care feels reactive and fragmented, there's an unclear plan or expectations, and there's a higher likelihood of unnecessary imaging procedures or surgeries and symptoms may worsen before action is taken. CM s s vision for this after ASM is that the clinician's approach transforms because they are accountable for the total episode cost and outcomes over time. There's an emphasis on early conservative management, avoidance of low value care such as unnecessary imaging, more active monitoring of patients progress, increased coordination with the primary care providers and care teams. And the decisions these clinicians will make will be influenced by the downstream impact that they're likely to see for these patients.

And a patient's experience might feel like there's more proactive and guided care, earlier intervention and clearer care plan, a greater focus on function and symptom improvement and a lower likelihood of unnecessary escalation and more continuity across the care journey. That is CM S S vision for ASM, which now we're getting the acronym acronym stands for the ambulatory specialty model. It shifts accountability from what

happened at the visit to what happened to the patient over time. So that is kind of the the vision for it. The way that they're doing this is in introducing financial accountability to incentivize care coordination for these clinicians.

There's going to be a reduction of unnecessary or duplicated services and enhancing overall care experience for beneficiaries. So today I'm going to walk you through an overview of the model and including the participants and selected cohorts. I will review the requirements by categories of category. By category, they should look like familiar categories if you've lived in the MIPS world, quality, cost improvement activities and promoting interoperability. I'll quickly walk through how to calculate your final score and then I'm going to be joined at the end with a colleague of mine to do a demo of Metasol Encore for electronic clinician measures. We're going to give you a little bit of a peek behind the curtain about how you might manage some of these measures found within ASM using the Metasol platform.

So that's today's presentation. Presentation take us about an hour to get through. We might have some time for questions at the end. And again, this is being recorded and their slide that you can download as well. All right, so to begin the ASM performance period, it is a five year performance period that actually starts next January 2027 and goes all the way through 2031. So where we'll be entering performance year one starting January 1 of next year. To kind of Orient you to this program, you can think of it like MIPS ASM participants. This is a new term, that's why I put it in quotes.

Those clinicians that are selected for the models are known as ASM participants. If you are selected, you are required to participate. It is a mandatory model for those clinicians who were selected as ASM participants. They carry out beneficiaries on behalf of Medicare beneficiaries and bill CMS. So normal course of business throughout the year and then during the performance year. They also will track different measures, how they're performing on different quality measures in the following year. They submit or are scored on these 4 categories, quality, cost improvement activities and promoting interoperability.

And depending on their score, they get a penalty or a bonus to their claims submitted in the applicable fiscal year, which is 2 years after the performance year. So next year starts performance year 12027. You go throughout the year, you bill as you usually do. These clinicians, do you track these performance measures, You submit it first bid of 2028 and then it affects 2029's payments. That's how it works. So they should all be sounding pretty familiar to you. Now, differences in the category weights you're used to, probably working on the left hand side of the screen.

You got MIPS, you got MVP, you got APP for any of our MSSPACOS. These are all governed under the quality payment program and within these different ways of reporting, Reporting frameworks they call them. Different categories are worth different weights in the ambulatory specialty model. Key difference is that your performance is based on cost and quality only and the other categories, your Pi and your IA can only hurt you for poor performance. That's the difference. So this ambulatory specialty model is different than the quality payment program and it pulls these clinicians out, mandates it for them and their scores based on cost and quality fit split evenly at 50 and 50%.

I'll go through that in detail as well. As we go now, like MIPS and MVP, it has two risk 2 sided risk adjustment down to -9 percent or up to +9%, but you know that is going to probably change over time. Within their language on their site, they said they intend to increase the risk number and there's some other things that will make this more difficult than what you might be expecting from the MIPS side. Like MVP, it is specially focused outpatient specialty care for chronic conditions. So MVP covers all the specialties, whereas this ASM has two specialties to begin with, and then like MIPS and MVP, it is mandated for those selected participants and in that they are excused from reporting MIPS or MVP.

Now, unlike MIPS, there is direct competition between specialist, no predetermined thresholds. So on the MIPS side, you're used to getting whatever you need to get, however you need to get it to reach a score of 75. That will not be the case for this one. Your score is based on how you perform compared to your peers. So it's completely dependent upon how all the peers perform for. Unlike MIPS, the reporting is according to the clinician level for quality and cost set of this big group 10 level.

That individual clinician level data is required for submission for quality and then evaluated for cost. Unlike MIPS, there's a requirement to connect with a beneficiaries PCP, so you must connect those that beneficiary to APCP. Unlike MIPS, you can also share money between the specialist who's required and the PCP. And then unlike MIPS, you can receive ongoing beneficiary level information to evaluate the beneficiaries costs and healthcare interactions. So that is quite different from what we know in the current model under MIPS. So ASM participant, somebody asked already, how do you know if you're selected? I've got a link here in the slides.

CMS has up an ASM participant data set that you can come and see. So right away, if you want to see if your providers are on this list, go to this data set. You can download the whole thing or you can search by an individual. MPI think it is now that is what their their current list is. However, Please note that they said they will update it in the summer, so July time frame they're going to update this list of ASM participants. So don't just look right now. You also need to go back once the updates done and confirm that there weren't any more added or removed.

So an ASM participant, this is the official, you know, CMS language is difficult, but it's individual clinician who for at least one ASM performance year satisfies the ASM eligibility criteria and has been selected for participation. Just like a bunch of words. But there's a couple of things that the way that they selected it, they have to bill under the Medicare physician fee schedule and they're using the episode based cost measures to attribute what your specialty is. You have to have a minimum of 20 episodes annually of these episode based cost measures. And instead of counting all of the individual visits, they consider complete episodes of care from start to finish with these episode based cost measures.

So that's like office visits, diagnostic tests, medications, hospitalization, follow up care. And then what CMS did was they selected a geographic area. 25% of CBSA is randomly selected. If this sounds familiar, it's exactly what they did with the team model. So if you're familiar with the team model, which was the hospital, they have everybody in these geographic areas that they call the Cbsas. And from there, they selected 25% of

those CDCBSAS and that's how they chose. Now for clinicians, it's kind of easier on the hospital side because there's a physical location.

But for clinicians, they looked back at the clinician's Medicare claims from two years before the performance year. They find the zip code that appears most often on those claims. And that zip code is the one that determines the clinician's location for the program purposes. So for the first performance year, this is the initial cohorts, there's a cardiology cohort and a low back pain cohort. So eligible clinicians who have been assigned A specialty code of cardiology on the plurality of their Medicare Part B claims. What that means is if you are a clinician who has submitted a bunch of Medicare Part B claims and in the example below there the plurality.

So it doesn't mean you know the majority, it means the plurality. So in this case 45% or cardiology claims while some of the others were of various, that means they were considered a cardiologist specialist in that example there same thing for the low back pain. These are eligible clinicians with a specialty code of anesthesiology, interventional pain management, neurosurgery, orthopedic surgery, pain management or physical medicine and rehab on the plurality of their Medicare Part B claims. That's how they were selected. Again, go to that data set to check it out. All right, we're going to move into the category requirements.

We will start first with the quality category. As I mentioned, the category weight for quality is 50% of your total score. It is similar. That is 365 days for the performance period, so all of 2027. The requirements are you must submit all required measures specified by the cohort and I'll show those here in a minute. You must meet the data completeness threshold, very important, and you must meet case minimum criteria. And as I said before, the quality performance must be submitted at the individual level unless the ASM participant is in a small practice, which CMS defines as consisting of 15 or fewer clinicians.

All right, so let's look at these cohort measures. This is the heart failure. So these are the measures that you need to track and report. Obviously, claims does not get reported, but the other ones, ECQMS or a MIPS CQM is the collection type for these measures. Please note that as of now, the functional status assessments for heart failure is only an ECQM. Therefore, if you have not historically been tracking ECQMS, this is one that you will need to get set up and make sure that you are tracking on behalf of whichever clinicians are included.

Now, looking at the low back pain again, we see a couple of similar patterns. There is a claims measure that they're kind of identifying as excess utilization measure, maybe MRI, lumbar, lumbar, sorry, lumbar spine for low back pain. But what they have, it is TBD in the calendar year 2027 rulemaking. So you can expect when the proposed rule comes out in June, they'll be more details on this claims measure. So take a look whenever that comes out in that time frame, June, July, somewhere around there. Now this one has some measures you might be more familiar with like screening for depression and the BMI screening and follow up plan.

Are my colleagues going to come on and do a view of what that screening for depression measure looks like? And then again, note down below the last one, functional status change for patients with low back pain impairments is currently only specified as a MIPS CQM. So if you only been tracking ECQMS, you need to have a strategy for the MIPS CQM as well. So they kind of get you on those, but I'm wondering if they'll

specify them for both in the upcoming proposed rule. We'll we'll have to wait and see. All right now I've included this data complaint is here and I've talked about this before.

It's been a hot topic in the industry, but I wanted to do it here because if you see where I've got bolded and underlined says if you do not submit at least one ECQM or CQM and meet the data completeness threshold, you fail ASM all together and get a -9% on your Medicare Part B claims. Well, that is intense. So if you do not at least submit one, which I think most people can do, but I it's just very strong language from CMS, you completely fail and you get a -9%. They're very serious about meeting this data completeness requirement for either ACQM or an ECQM.

But what they really want you to do is data completeness on all of them. So you have to meet these thresholds. So essentially, it's easier to understand on the ECQM side because ECQMS, if you report through a certified EHR record, you include all of the data that's for that patient, for all of your patients, then you receive and achieve the 100% data completeness. So ECQMS, by the nature of being an ECQM, have all the data completeness that is required. But if you are doing a CQM where there's some manual review of the data, CQMS are where this data completeness requirement comes into play.

CQMS is calculated by considering both the total number of patients seen who are eligible for a measure and the total number of patients for which you report. So the key is numerator over denominator and the denominator is the total number of patients eligible for the measure. So across all settings, across all practices. And if it's, if it's applicable for you as you're going, this is probably a little bit easier because it's at the individual level, but it's the total number of patients eligible for the measure over the numerator or under the numerator. And the numerator is the number of patients for which you report performance data in a CQM world that's performance met, not met or denominator exceptions.

So if you cannot find the answer to answer whether it's met, not met or in second exception, then it would be incomplete data. And you can have a greater than or equal to 75% or you must have greater than or equal to 75% data completed for that. So hopefully that makes sense how this is here. Make sure you're really clear on getting all of the eligible patients for the measure and you will you will meet your date of completeness requirements there. OK, Last thing is case minimum, so 20 denominator eligible instances. And if the measure does not meet the case minimum requirements, the measure will earn 0 deaths out points.

Last thing to note here is that they're going to be special benchmarks for these quality measures for these cohorts. So you cannot just expect to use the same measure decile that you are using in MIPS. Hopefully you know what I mean when I'm saying these decile which are the things that earn you points. And you should note that that is what will be different for the specifically for these cohorts. So keep an eye on that as they provide more information. OK, moving on to cost. Cost again is worth 50% of the total score. It also has a performance period of 365 days the year.

And CMS is going to use those same episode based cost measures. So the same ones they used to evaluate whether or not you're eligible. It's the same episode based cost measures. They had the 2025 versions out there

right now that you could actually go look and download and review what's all included. Of course, they make you go somewhere else to look at all of the things that are included for those particular measures, but there's one for heart failure and for the low back pain as well. So it uses the episode based cost measures.

It compares your total Medicare spending per episode versus other specialists. So this also is comparing how you have spent compared with your peers. Now it's scoring based on the standard deviations from the cohort median, which if you're not a math person, it basically means where everybody fell in the middle and then how far of a standard deviation, which means how far out are you from the middle. Just like in the simplest terms, what you can mostly expect is that if you have lower costs as compared to your peers in the cohort, everybody in your cohort, generally you'll get a higher score.

Now they will provide some adjustments for patient complexity and other factors. And again, just like the quality measures, you must have greater than or equal to 20 episodes for scoring. What I've got on the right hand side of the screen is illustrative. It is not for sure how CMS is going to do this, but I wanted to make sure you guys had an idea of what this might look like. So if you are right in the middle range and you don't have any difference from where you are in that median versus according to the standard deviation, you'd be at 0.

Then maybe you'd be in the six range, 5 to 6 range or something like that. And you can see the further away you are from where everybody else was on cost, the lower your points and the greater you are, meaning how much you understand, then the more your points will be on cost. So hopefully that makes sense on how they're going to do that. But we don't have the exact methodology yet of what that standard deviation will be like for those benchmarking range. All right, moving on to improvement activities. Remember, improvement activities have no weight and it has a negative impact only it is similar to what you're expecting on the IA side.

For the MIPS it is a 90 day performance period and what you have to do is you have to complete 2 activities, the same activities for each cohort. You if you only complete 1, you lose 10 points from your final score. If you complete neither, you lose 20 points from your final score. But if you do not attest yes or no to both, you fail ASM all together and get a -9% on your Medicare Part B claims. So again, really strong language. And it doesn't mean you have to say yes to both.

It means you must attest either yes or no to both or you fail all together and get that -9%. So you can see it's just these two activities and you have to do both in order to not get a negative amount to your score. These are the two activities that you must do and it is a penalty if you do not. The first IA 1 is primary care connection and HRSN screening, so you must help patients find primary care providers if needed. You must communicate with PCPS after every visit and you must ensure patients get health related social needs screening. Yes, it's those SDOH screening measure questions.

So if you are familiar with those SDOH screening measure questions, which they took out last year, they actually kind of slyly put this one in here too. Now, it doesn't say that the specialist must complete the SDOH screenings. They don't have to complete it themselves. They can. What they must do is make sure that it gets

done for the patients. So that means maybe when you connect with that PCP, you ask them to complete the health related screening. So that's the first one. The second one is collaborative care arrangements.

You must execute a formal agreement with a primary care practice. It must include three of five elements. You could do data sharing, Co management, care transitions, closed loop communication and care coordination integrations. There's all these details behind these measures. Of course, that's specific things you must do to attest yes to these two improvement activities. But I have a little bit more about that collaborative care arrangement here. They call them the CCA. You must enter ACCA with APCP for ASM, very clear. So you specialist can within this collaborative care arrangement, you can make these different arrangements with a primary care physician and you can pay a primary care practice for coordinating services.

The primary care, the specialist can pay the primary care practices for this coordination of services and the primary care can pay a specialist for things like consulting or training, something like that. And there's some legal protection from anti kickback violations. There are specific requirements around these CC as it must be a written agreement, fair market value only, no conditioning on referrals, and must advance the ASM clinical goals. So if you hadn't had a chance to look through those improvement activities and what's required of your clinicians, please do because they'll want to start thinking about which practices they want to engage with this in 2027. Again, it has to be 90 days.

So you do have a little bit of time into 2027 to get these ones set up and arranged. Did I say 9090 days? I hope I said it all right. OK, Promoting interoperability is the last category. This also should look pretty familiar. Couple of key differences again #1 there's no way it is a negative impact only. And the way you think about this one is that unless you're perfect, you're going to get a negative score in promoting interoperability. So the performance period is 180 days. That is the same as the MIPS one.

The requirements look very similar. Submit the required measures. I'll show you that you must attest to the ONC direct review. But subbullet, you do not need to attest to the actions to limit or restrict compatibility with interoperability of cert Attestation don't have to do that attestation. You must have certain function cert functionality that meets that ONC certification standard in place by the first day of your MIPS Pi performance period. And they call it MIPS Pi just to confuse everyone, but they mean this promoting interoperability. You have to have your EHR certified to the ONC to the certified criteria, blah, blah, blah by the last day of your performance period as well.

So you just have to get it set up in the performance period that you're measuring. You must provide your CMS identification code, conduct a review of the security risk analysis on your cert on an annual basis and attest to a conducting an annual assessment of the safe, Safe safer guides. So that should all look pretty familiar to you for API and these measures should look familiar to you as well. So you want to get as much as you can on these ones. So E electronic prescribing for E prescribed query PDMP, you can get a 10 points, 10 points and they're required in the health information exchange.

You have three options for how you're going to get those Max of 30 points. They're provided to patient exchange. 25 points also required the public health and clinical data exchange. In this category, electronic case reporting immunization registry are required to get and you can get a maximum of 25 points. You will note there are not those optional bonus measures here, so they did not give the option to get additional bonus points. Here's how it's going to work on this side. For promoting interoperability, you must report at the group level, the TIN level.

So Pi and IA are reported at the group level, whereas quality is at the individual level and cost is associated is evaluated at the individual level. There are no bonus points available for optional measures. Then the penalty calculation I've given you the way that they're going to do it, their score times 100 -, 100 / 10. So here's your example. If I achieve an overall score of 73% in Pi. So you see on the right side step by step calculation 73% performance score you you earned 73 points. So first multiply the score by 173% * 100 is 73.

Subtract that result from a hundred 100 -. 73 is 27. Divide by the maximum negative adjustment, which in this case maximum you could lose on Pi is 10. So 27 / 10 is 2.7 and applies a negative adjustment. So my final scoring adjustment will have -2.7 points because I wasn't perfect. So you must achieve 100% to not get a negative score on the promoting interoperability portion. All right, so let's move into the performance threshold about how they're calculating. As I mentioned, for unlike MIPS, there's no specific threshold to achieve.

Your score is completely dependent upon how you score in comparison to everyone else, so you're not trying to achieve 75 points here, you're just trying to Max out your points. There are a couple of specific bonus point opportunities in this program. One, if you're a small practice or a solo practitioner. Small practices 2 to 15 clinicians get an extra 10 points. A solo practitioner gets 15 points. There's also a complex patient bonus similar to how they're treated in the other one as well, up to 10 points for treating sicker, more disadvantaged patients.

And CMS will base this on the HCC risk scores and dual eligible percentages must be above cohort median on greater than or equal to 1 indicator to qualify. So you have to have this level of complex patients within the patients that you served, and then CMS will add your complex patient bonus on top of it. So this is an example of what that final score calculation will look like. Let's say I got 50% on quality or sorry, starting again, formula, final score quality is worth 50%, cost is worth 50% * 100 plus the IA adjustment if you have any negative, plus the Pi adjustment, plus any additional complex patient bonus plus the small practice bonus.

So that's the formula they're using. So I've given you an example here. Let's say Doctor Flower had a quality score of 80%, a cost score of 75%. There were fifty, there were 50% each and you times that times 100. So the base points that I earned with that is 77.5 points. Now let's say for IAI was only able to accomplish one of those improvement activities. So I'll get a -10 on that. Then I showed you the example of the Pi and in that case I had a negative 2.7.

Now let's say I have some complexities. They give CMS assesses and gives me a positive 5.5 from my complex patients and I'm a small practice so I get plus 10. In those instance, the final score would be 80.3 points. And you're like, great, is that good or is that bad? We don't really know because there's no minimum score required to pass. Your performance is evaluated relative to other clinicians in your specific cohort. And they have payment adjustments, whether positive or negative, are based on how you rank compared to your peers.

So this is based on what CMS heard from you guys about how winning in MIPS earned like a maximum of 2% adjustment. So it wasn't enough money for you guys to feel like this is worth all the effort to do so. They are making it differently in the calculation here and they're doing that specifically because they want to reward bigger the winners and reward worse whatever the correct arm is there for the people who don't perform as well. So it's more risk in this model for sure. All right, couple of final considerations here as we come to the conclusion data sharing opportunities, I mentioned this at the top clinicians will get regular aggregate and patient level beneficiary files if they would sign up and agree to the state of sharing terms with CMS.

There's two you could get the DE identified performance trends, cost utilization, quality data and regular intervals during the performance year or by request you can actually get patient level data which would provide the details of Medicare Part Abd claims it is for participants, ASM patients only. That's part of it. You have to sign this data sharing agreement and it can be used for care coordination and quality improvement. That should also sound familiar to you if you have any knowledge of the team program because they also are providing those data sharing files for those in the team program as well. A note about overlap.

CMS specifically in the rulings talked about how they designed this to overlap with both AC OS and other Innovation Center models. Basically, you could be an AC O and also be an ASM and you can get the shared savings and you can get these ASM bonuses as well. So there's a lot of kind of information about that. It's a little less clear to me on some of the other specifics about how the AC OS have to handle them, but I'm sure we'll get more information as these, there's more stuff that comes out on their website and as the new ruling comes out to anticipation of the 2027 start.

So how you're going to succeed? The winners in this model will be specialists who embrace systematic quality improvement. You must build strong primary care partnerships, invest in care coordination capabilities focused on evidence based cost effective care. So what is the thing that's going to drive down cost and also have best outcomes for client or for your patients and that adapt to data-driven practice management. And if you're thinking about the future of this, what ASM means for this future, if it's successful, expect that they're going to expand into other chronic conditions and specialties. This will be the template for specialty payment reform across Medicare.

If this goes well. It's kind of the first indication. Generally, they play around with the CMMI, which creates all these different models that you can voluntarily be part of, but this ASM is mandating it for certain clinicians. So you can expect that they've feel like they're making progress with the models that they've tested out and that if this one goes how they think it's going to go, they're going to add in more and maybe eventually and volume

based independent specialty specialist practice maybe. So CMSS message, they really want specialty data, whether it's in here or whether it's in the MVP program. The future belongs to collaborative accountable specialist and patient outcomes in care coordination.

Dr. financial reward. So I've covered basically what ASM is and how scoring works, what CMS is ultimately holding organizations accountable for. The next question we typically hear from quality teams is how do we actually do this? How do we track these measures accurately across systems over time, especially when we're being evaluated on longitudinal performance and total cost? So that's exactly where making sure you have the right measurement infrastructure becomes critical. And at Medisolve here, we've been focused on this for a long time.

Even when the transition from PQRS into QPP, we started developing the tools to help clinicians succeed within those as well. For ASM specifically, you have to be able to support both ECQMS and CQMS and have one vision of that so that teams, whoever is managing that team, can drill down into the individual clinician level, but then also kind of have that zoom out to the broader picture as well. So it's not just about making sure you're compliant, but you have to think about the whole picture of what you're doing across your quality payment program, MIPS and MVP. And now for these specialists as well, you need to have performance level visibility all the way down and all the way up as well.

So that concludes the educational portion. And right now I'm going to turn it over and welcome colleague of mine, Jen Miller. Jen, if you want to come back on, she is our senior product Manager here at Metasolve. Jen in a past life was our ambulatory specialist as well. So Jen kind of geeks out on this stuff as well. And I know even though she's in this, the product manager role has read a lot of this. Jen, your thoughts on this program? I'd see you've also been answering questions in the chat.

Any any commentary on any of that? Yeah, I was trying to get to a few of those questions in the chat. I know you hit the nail on the head when you say it's really unclear to us how this ASM model is really going to interact with AC OS and what exactly those clinicians that are part of an AC O will be required to submit. So that was one of the questions that I saw on the chat. A couple other things, you know, when I'm thinking about this ASM model, like it's really clear to me, CMS really wants that specialty data.

They want to be able to compare like clinicians on the measures that they have selected. So that's why they've mandated, mandated this. And I think, you know, they tried to do that with the MVP program, but weren't getting necessarily the data that they thought they would or that they wanted to do that comparison. So this is just another step in that direction. It is funny because from the stage, CMS was like MVPS, it's simpler, there's only four measures, right? And in this case, it's like, Oh yeah, it's simpler. It's a smaller cohort. But of course, the complexity really maybe lies in the data and and aggregating it.

I don't know. What do you think it? Because I really don't think it feels simpler. Yeah, I don't think it feels simpler. I mean less measures for sure, but you are now instead of looking at an aggregate result for your entire group, you are focusing on each individual clinicians performance. So if you are a quality leader, instead of

one group score, you now could be responsible for several different individual clinicians score. So definitely increases, you know, the burden on the quality leader there. Yeah, right.

I mean, that's great point, right. You're responsible for the score, but also the submission and you were doing one. With MVPS you might be doing 20 but with ASM you might be doing hundreds so. Great. So I appreciate you spending all the time with us today. Jen's going to walk us through a demo. Just wanted to make sure it was clear to everybody on the call. We have our Quality IQ platform, which brings together those measures from those different platforms.

So the ECQMS and the MIPS CQM's. Basically, our infrastructure brings together this unified data across clinicians and systems and that's going to be really important for you as well. It's that complete measure coverage across those different ones. All required ASM measures are part of that and it gives you that performance in real time. We'll call it real time, but really that just means like more regularly than just submitting it at the end of the year. And however often we prefer it depends on your size. At least every month you're looking at this information and understanding where your fallouts are, but obviously more quicker than that would be better gives you that actionable insights.

And this is really what you need based on what Jen and I were just saying, this scalable system wide quality measurement where you can look across all those different clinicians and practices and specialties and locations and you're clear that the data is clean and accurate and you can drill down to the individual specialty and specific clinicians. So with that, I will pass it over to Jen to give us a demo of the electronic clinician measures mentioned a couple of different products there. But today we're zooming in specifically on an example of how ECQMS are in our system for and I think that you're going to do the depression screening measure, right? Yep, that's correct.

All right, take it away, Jen. All right, Aaron, if you could just let me know when the screen is sharing. Yep, sharing now. OK. Thank you. All right. So as Aaron mentioned, this is a look at our Encore for electronic clinician measures application where we support ECQMS. So I'm starting here on the clinician ECQM page. And for the sake of the demo today, we're going to be focusing on preventative care and screening, screening for depression and follow up plans since that is one of the ECQMS that is in the low back pain cohort.

So in our application, we have a lot of things that are right at your fingertips so that when you're reviewing this information, you don't have to go out to other websites to look for this. You can just pop into our application and have everything available to you. So the first thing we have here is the measure specification. So you're able to open this up right within the application so that you can review that information. Of course, at the top of that measure specification is the human readable component. And then as you Scroll down, you get actually into that measure logic, that CQL logic.

And then further down into the specification, you get into the actual terminology value sets in the data elements that are part of that measure. Across here, we have the CMSAD measure name, the type of measure, measure version, and then you have your population denominator, exclusions, numerators, and then the overall

rate and those decile points that correspond to the rate. You'll notice in our demo system, we do have a large initial population, 14,000, which seems like a lot, but if you're not familiar with this measure, it does have one of the larger initial patient populations due to the age range. So this measure looks for patients that are 12 and older, and it also has several different types of qualifying encounters.

So there's telephone encounters that come into this measure, physical therapy encounters, and then as well as your specialty appointments and then regular office visits. So I'm going to go ahead and click on this plus sign here. And thus will display all of the patients that have qualified for the measure. And to review this further, I'm just going to group by results and then this will group this by patients that have met the exclusion, patients that are in the denominator only, and then patients that are part of the numerator For the demo, I'm going to open up a numerator patient.

So I just clicked that plus sign. There we have the patient that's qualified for the numerator and I'm going to open this up so you guys can see what our patient details page looks like. So at the top of this page we have all of the patient demographic information. We have the name of the measure that we're viewing along with that specification again. And then we have tabs for conditions and counters all the way through here. And this is where the data from your EHR will populate into our application. So I can click on the encounters tab and I can quickly see that this patient had a qualifying encounter.

It was documented on 3/4 and this is the provider that they had the encounter with for depression screening. I'm going to look at that procedure tab and I can see very quickly that this patient was screened for depression. They had a negative screening and I can see exactly when that screening occurred. We also have our patient visualizer tool here. So what this does is this is really helpful for identifying where a patient has fallen out of a measure. So clicking on that magnifying glass will display all of the, the the measure information at the top as well for the patient, patient information, and it will draw out all of the qualifying data elements.

So if you're reviewing a patient and they have had several different encounters throughout the year, they've had a lot of procedures documented, a lot of conditions documented, this will pull out the ones that are relevant for that measure and display them right here so that you're not struggling to review all of that information. The other thing that it does that's really nice is if you click on View Data Evaluation, it will lay all of that information out for you in that measure measure specification format. So in that CQL logic format. And what it does is it will highlight in green where a patient has met this criteria.

So you can quickly see this patient is part of the patient population. They are over the age of 12 and then it will highlight exactly where in the measure logic it has met that criteria. So you can see here my numerator is green, but then as I scroll you'll see these things are in red. So that means that the patient hasn't met this criteria, but they have had an adult screening that was negative. So that is why that they are in the numerator for this measure. Now I'm going to go back to this page here because more important than the numerator patients are your denominator patients.

So these are the patients that you want to review. Well, first one, identify them. Then you want to make sure that you are reviewing them to see and look for opportunities for when you could have that patient screened and the appropriate follow up documented to improve your performance. So we provide this view here. So you could go ahead and have a working list. If you are focusing on closing those gaps in care, you would have a working list that you could use to do so. The last thing that I wanted to show really quick is a tool that we use a lot and I know our customers use all the time as well, and that is our validation and improvement dashboard.

And within this we have a value set quality check. So I'm just going to pop that open and go to CMS to the depression screening measure that we were looking at earlier. It's going to select that here. And what this does is this will display all of those value sets that are part of the measure. So it displays those here along with the description, the type of value set it is. It displays the number of codes in the value set. And then what we like to do when we're looking at improvement of a measure or making sure that we're capturing all of the data and that everything is mapped appropriately is we like to focus on where the patients with codes is either missing, so showing a 0 or this number is low.

So you can come in here quickly, you can just type in a zero and you can see very quickly where the gaps are. So I can tell right away that we are not capturing any adolescent depression screening assessments. Now that could be for a number of reasons. That could be maybe something that's not being documented at the organization, something that maybe is documented but not being documented in a discrete field, or it could be something that just isn't isn't mapped appropriately to one of to that blink code. So this is one of the ways that our customers and us here at Metasol use this tool to help drive the improvement of the ECQMS.

OK. And Aaron, I'm going to stop sharing my screen and and bring it back to you. Awesome. Thank you, Jen. That was Great Depression screening. Such a a hard measure, right? It's kind of it's got low performance across the board for at least the ECQM version. It does, yeah. A lot of those specialty visits specialists struggle with that measure, which is probably why they added it to the low back pain cohort to help drive the improvement there.

But it is one of those measures that we see kind of across the board have lower scores for an ECQM. Yeah, which you know, OK for the death styles, but I wonder if somebody can figure that out, what the right path is for getting that figured out. Could maybe use that to really excel within the program. Awesome. So we've got 10 minutes left and we got a whole host of questions. Can you stick with me and help me answer some of these questions here live? We'll just kind of back and forth it for what we do and don't know.

Sure. OK. So just do our audience. First, I'll say these are a lot of difficult questions that you have submitted and there's not as much information on this particular topic right now. So some of these we don't have answers to anything that we don't know, don't have an answer to. What I'll do here for our broader audience is I will create just a document that helps answer some of these if any of the questions we need to do in a follow up or get CMS. So if you are a current Metasoft client and you have access to the Quality Academy, we usually will answer these on our live weekly Q&A that occurs and we'll do a written document.

So I'll still do that for our anybody that's a Quality Academy attendee who happens to be on this call as well. If you're not a current client, you'll have to come back here and look for that document whenever we get it up and up and running. OK. So let's start at the chat plurality. What if the card claims had been the smaller number? I think what you're saying is if you're not seeing the plurality, and this has to do with the specific way in which CMS is evaluating your specialty cohort, I would just point you back to the participant list.

Look at that participant list and see what, if they are on there, what they're qualified for. If you think it's an error, you'll have to reach out to CMS to ask for proof of the claims for plurality to confirm that that truly is the specialty code that should be applicable to that specialist. Are hospitals obligated to report on behalf of their clinicians, or is this something clinicians should do on their own? I mean, I don't know, Dan. It feels like that's a decision that should be made by the group. What do you think? Yeah, I agree.

And I know we see it both ways. We see some independent, you know, clinicians reporting on their own most of the time. I will say we see organizations, you know, reporting on behalf of their clinicians. I think it goes back a lot of times to how those clinicians are billing. Are they billing under the hospital or organization's TIN or are they, you know, billing under a private tax ID and being reimbursed that way? OK, yeah good For multi specialty practices, let's say it's cardiology and PCP under the same tin, would the CCA count within the same group?

I mean that's a great idea. I don't I don't know for sure, but seems like that would make sense. I something to ask CMS. Any thoughts on that one, Jen? I agree that's something that would make sense, but I would verify that with CMS as well. Yeah, our providers, next question. Our providers are hospital associated. Would we submit MIPS for the rest of the providers or only submit the ASM for the two groups? Doesn't MIPS go away? So now my understanding is you've got to submit MIPS at the TIN level and then separately you've got to do these individual ASM clinicians.

You agree with that assessment? Yes. Yep. OK. Yep. So more work. OK. As an AAPM, we automatically got credit for cost and interoperability. Does that exist here? So an AAPM, the advanced alternative payment model, my understanding is those clinicians are completely exempt all together because they have this special designation that gets them like the automatic, whatever that percentage is.

Is that your understanding as well for Aapms? Yeah, yeah, that's my understanding as well. OK. So yeah, I don't think it'd be applicable here, but I would check to see if your clinicians are on that list. If a selected participant is exempt from MIPS reporting due to participation in an APM, you know, reach and or the lead model, does participation in the ASM model bring them bring back the burden of MIPS like reporting obligations in addition to the reporting already required under the APM? You know, that's what I'm like less clear about is how they're going to work at the measure requirement in.

I haven't seen any specific clarifying information other than they can share. They can get any of the benefits of being an ACO from like a payment standpoint and being an ASM, but I'm not clear if that means they still have to do the reporting for MIPS for them. I think they do, but what I don't know. Have you seen anything,

Jen? Haven't seen anything. They've stated specifically that they can report both, but they haven't said anything about not having to, you know, report through ASM. Yeah, CMS to just like leave it vague until they decide.

So maybe in the ruling is there a free collaborative care arrangement template available? I didn't see anything in the in the documentation. The only thing I've read about it is in the ruling. Have you seen anything else, Jen? I have not. Yeah. So in the ruling they give some more specific information about those collaborative care arrangements. So I'd read that I can always make one up based on that. But they they'll they'll give you that as as it kind of goes on here.

OK. For the heart failure ECQMS, are they an either or for the ECQM ones or are both required? I think what the question is like on that list, if you if they are specified as both an ECQM and CQM, you can choose between the which one, right? You don't have to submit. Both, right. I kind of took the question the other way because there are two different heart failure measures and they're both required. They are measuring something different. So I guess we kind of answered it two different two ways.

So you can choose the collection type, so either ECQM or CQM if that was the question. But if you're specifically asking, you know, measure 5 or measure 8, you have to report both of those. OK, great. Thank you. Sorry, I didn't catch catch that one. Clarifying how often providers are select, whether it's per cohort in performance, year 1 cohort per year, or if one cohort is selected every five years. It's re evaluated every year from my understanding of what I read. So each year could potentially be in or out of the cohort.

OK. Some questions that were submitted in the question box. The question was, does Medsolve have a resource that can help estimate the impact of the payment adjustments for Part B? I've seen an Excel sheet with billable services for the OQR program that can estimate financial impact. Having something for MIPS ASM that we can use to estimate financial impact would be a great help. Jen asked me this specific question and was helping me to work on this as well. We were trying to come up with something as a tool again for our Quality Academy users.

Anybody logged into the Metasol Quality Academy where you have your tool boxes? We have that financial calculator for all of those different programs. We don't have 1 yet for the MIPS ASM. It's a little bit more complicated to try and get that information from you guys, but if you can get that Part B information, I think we can come up with something. So I guess stay tuned. We're working on it. Jen and I have some ideas around it. If a selected participant is exempt from MIPS reporting due to participation in an APP model.

Oh, we already answered that one. Sorry. Let's see what else we got here. Somebody says, I checked the list. None of our providers, MPI seem to be on the list. Does this mean we are excluded or don't have to worry about this at all? Or do we still need to do something for ASM if there's no MP is on there as of right now, you do not remember they're going to update the list in July. Go back and check it somewhere they said so go back and check it once it's updated, keep an eye on the ruling to confirm that they don't add new cohorts for for you know, upcoming years.

And then after that, yes, you do not have to necessarily do anything there except for, you know, keep your finger on the pulse of what's happening. We answered the one about selected for one year. OK? We answered that one. OK. I think we got through all the questions just on time. So thank you all so much for your participation in today's webinar. Thank you, Jen, for joining me today, helping answer the questions and to provide a little insight into the Encore tools here at Medisolve.

We appreciate the time you guys have spent with us. We hope you'll consider Medisolve as your software solution as you try and navigate the quality payment program and these new models like ASM. Thank you so much. We hope we have a great rest of your week.