eCQMs for ACOs: Recommendations from the NAACOS Digital Quality Measurement Task Force

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Executive Summary

The health care industry has long struggled with interoperability across providers and settings of care, and it lags behind other highly regulated industries such as banking. An efficient, technology-enabled future where data can be shared bi-directionally to better inform patient care is the future state many in the health care industry want to achieve. This future state could also facilitate the more efficient exchange and evaluation of quality data, thereby reducing administrative burdens that currently make quality reporting difficult and costly. While this efficient, technology-enabled quality reporting is a future state the health care industry should strive toward, recent changes implemented by the Centers for Medicare and Medicaid Services (CMS) to the Medicare Shared Savings Program (MSSP) quality program go far beyond simply digitizing the previous well-established process.

As CMS attempts to move the MSSP closer to this future state of interoperability through the required use of electronic clinical quality measures (eCQMs), the agency must address the unintended consequences and implications for ACOs, the clinicians in those ACOs, and the patients they serve that must be considered, including misrepresenting the quality of care provided to ACO-assigned beneficiaries with changes such as the expansion to all-payer measurement and increasing administrative burdens. The MSSP program-wide pay-for-performance implementation of eCQMs should not move forward without proof-of-concept of both technical feasibility and the impact of the shift to all-payer/all-patient measurement that accompanies eCQM reporting. CMS must also consider the future digital quality measurement (dQM) goals and how ACO eCQM requirements fit into that larger goal. This paper offers several specific solution-oriented recommendations for acceleration of technology readiness, reduction of administrative burden, and avoidance of unintended, harmful consequences as CMS moves forward on the path to digital measurement and interoperability.

CMS must not move forward with the all-payer requirement for eCQMs and Merit-based Incentive Payment System (MIPS) Clinical Quality Measures (CQMs) when applied at the ACO level.

Requiring ACOs to report on eCQMs/MIPS CQMs requires ACOs to collect and report on a broader set of patients than they have been evaluated on previously. Specifically, performance is no longer limited to a sample of the Medicare-assigned beneficiaries for ACOs, but rather all patients meeting the eligible population criteria, regardless of whether the patient is an ACO-assigned patient or who the payer is. to all-payer data has unintended consequences and will result in ACOs being measured not on the clinical quality of care provided, but rather the composition of the ACO as well as the ACO's payer mix. The all-payer requirement also exponentially broadens the patients an ACO will be assessed on, introducing new challenges and adding significant data extraction costs for certain ACOs, as well as measurement validity concerns and privacy issues. Most importantly, the all-payer requirement has the potential to have the unintended consequence of penalizing ACOs serving high proportions of underserved patients. In this case, ACOs serving these patients may choose to exit the program or limit ACO participant practices to limit the negative effects of this requirement.

The shift to all payer data has unintended consequences and will result in ACOs being measured not on the clinical quality of care provided, but rather the composition of the ACO as well as the ACO's payer mix.

CMS must ensure all-payer performance data is not used for determining payments. If CMS does not remove this requirement, CMS should consider alternatives such as relying on all attributed ACO patient data or applying a different attribution approach that is less broadly applicable (e.g., exclude specialists in a way similar to what is done for the MIPS cost measures).

Electronic health record (EHR) certification criteria must support ACOs in what they are required to achieve for electronic clinical quality and digital quality measurement.

The current state of data standards and interoperability will not yet fully enable ACOs to meet the eCQM reporting requirements successfully. The requirements dictate ACOs will need to collect and report data from multiple practices and EHR vendors across all of their ACO participant Tax Identification Numbers (TINs). A recent survey of the NAACOS membership found that only 17 percent of respondents use one EHR, 24 percent use two-to-five different EHRs, and 20 percent use between six and 10 different EHRs. While CMS and others often assume that EHR vendor systems with 2015 Certified Electronic Health Record Technology (CEHRT) would automatically include the capability to easily report the most recent version of an eCQM for MIPS with minimal manual effort, that is not the case. The CEHRT requirements do not standardize the capture and reporting of individual eCQM data elements across vendor systems, and ACOs will still need to tailor data extracts and uploads across systems and participating TINs. Additionally, not all CEHRT vendors will implement every eCQM required for reporting, since it is not a CEHRT requirement, potentially leaving a gap for ACOs. This paper outlines the minimum conditions to meet current requirements for ACOs to be successful in eCQM reporting in the short-term, as well as business requirements for the longer-term/future state CMS hopes to achieve.

CMS must identify an alternative pathway to transmit data in a standardized way to enable successful patient matching, such as use of a national patient identifier or revisions to Quality Reporting Document Architecture (QRDA) I formats.

Based on the current requirements for ACO reporting of eCQMs and MIPS CQMs, ACOs must be able to de-duplicate data across multiple practices to create the single data file for each patient necessary for each measure. These data would be generated using QRDA I files (patient-level), and then once patients are matched, the QRDA III file (aggregate at the ACO level) can be created and submitted to CMS. In the absence of a national patient identifier, ACOs must find solutions to enable this patient matching. CMS must develop additional guidance and standards for ACOs regarding how CMS expects patient matching to be completed.

CMS must provide the industry with greater standardization of data to assist in the highly burdensome process of data mapping and other workflow changes that will be necessary to transition to eCQMs and dQMs.

Like other quality reporting methods, eCQMs require workflow changes to capture appropriate information in the EHR in the appropriate location, particularly as measures change. CMS must recognize these burdens as it considers modifications to measure sets and must work to create stability in the programs to minimize the need for constant changes. These burdens fall directly on clinical staff already overburdened by administrative

issues and can be significantly higher than those associated with a sample-limited annual data reporting effort like the Web Interface. Further, if CMS later chooses to move forward with Fast Healthcare Interoperability Resources (FHIR)-based Application Programming Interface (APIs) to enable digital quality reporting and measurement, a different set of data mapping and workflow changes could be necessary. Therefore, CMS must accelerate the rate of adoption for EHRs to have the individual data elements required in an eCQM. Specifically, while we do not believe that requiring specificity on where the data elements are located across all EHRs is desirable, it is imperative that we achieve a vocabulary (including definitions and standardized value sets) that is shared across all settings including those devices outside of the traditional EHR that are capturing eCQM data elements. This approach will promote alignment of the data used by various payers, vendors and clinicians across programs and ideally reduce the workflow changes that will be necessary as measures are updated and/or added.

CMS should allow for alternative data completeness standards for ACOs reporting eCQMs or allow for exceptions/exclusions.

ACOs must ensure that the data used for quality measurement are valid and representative of ACO performance using a broader patient population (reflecting the all-payer requirement). They must also meet the data completeness requirements outlined in MIPS, which require aggregation and analysis from a broader set of patients and practices than previously encountered by other MIPS participants. Currently through the Web Interface tool, ACOs spend significant time and effort to ensure that the data submitted to CMS accurately reflects the quality of care provided to ACO beneficiaries. Dedicated staff comb through patient records to ensure that the right data for the right time period are identified and included in the measure calculations. While the current process uses a sampling methodology, the shift to eCQMs and MIPS CQMs requires that ACOs submit data on 70 percent of all qualifying patients who receive care from an ACO participating practice, which expands the denominator dramatically. CMS should consider the goals of data completeness requirements for ACOs reporting eCQMs, who will be reporting on thousands of patients.

CMS should provide policy incentives to help offset the enormous initial and ongoing costs associated with transitioning to eCQMs and dQMs, including making clinical quality measures pay-for-reporting, ensuring shared savings are not at risk, and/or setting alternative financial benchmarks for those who voluntarily test eCQM and dQM reporting.

While the goal of moving to more digital quality measures is laudable, the costs and administrative burdens that are being placed on ACOs should also be discussed and acknowledged. These costs and additional staff time are significant and are not being funded or supported in any way by CMS or other stakeholders. In a recent NAACOS survey of members, 50 percent of respondents reported the work to transition to eCQMs or MIPS CQMs for the first year of reporting would cost $100,000 to $499,000, 16 percent reported a cost of $500,000 to $999,999, and 16 percent reported costs over $1 million. Additionally, 40 percent of respondents noted they were not sure when they would be able to report eCQMs, suggesting that many

It is imperative that we achieve a vocabulary that is shared across all settings including those devices outside of the traditional EHR that are capturing eCQM data elements.

ACOs are still in the early planning stages.

Additionally, CMS should provide certain policy incentives to help offset these costs. As an example, CMS could make all clinical quality measures pay-for-reporting for ACOs who elect to move to eCQM reporting to ensure their shared savings would not be at risk if they make the financial investments necessary to transition to eCQMs or dQMs. CMS could also consider making alternative benchmarking policies for those ACOs who report eCQMs or increasing shared savings rates for those who pilot eCQM reporting.

CMS must pilot use of both FHIR-based APIs and QRDA I/III reporting of eCQMs with a small number of willing ACOs before moving forward with a program-wide requirement.

Given CMS and Office of National Coordinator for Health Information Technology (ONC) efforts currently underway to transition to FHIR-based APIs to support quality measurement and reporting, it is not sensible to move forward with a program-wide implementation of eCQM/MIPS CQM requirement for ACOs. Given QRDA limitations and CMS's focus on the future of FHIR-based standards, it is logical for CMS to begin piloting use of FHIR-based APIs with a select number of ACOs of varying size, composition and current capabilities. CMS could easily allow for this by including FHIR-based APIs as an acceptable standard for submitting quality data and testing through a limited pilot both QRDA I/III and FHIR-based API reporting of quality data with a small number of ACOs, such as 10 ACOs. This further emphasizes the need for a small pilot of ACOs to test more digital quality measurement efforts including eCQMs and FHIR-based dQMs, before subjecting the largest alternative payment model (APM) — MSSP ACOs — to a requirement that may be soon obsolete.

Conclusions

As CMS and ONC consider the future for digital quality measurement, the goal should be to improve how quality data can be captured to better support patient care at the point of care and appropriately reward high-value care. NAACOS supports moving to more digital sources of quality measurement that would allow the bi-directional sharing of near real-time quality data to improve patient care. However, CMS must use caution as the agency moves toward this goal. CMS should engage stakeholders throughout the process to identify unintended consequences and to ensure goals and timelines are feasible. The transition to this dQM future must be iterative and build off of previous work and investments. A more equitable approach in the current state is for CMS to first pilot eCQMs/MIPS CQMs for ACOs with a select number of willing participants before implementing program-wide requirements. In addition, CMS must provide strong incentives to those willing to participate in the pilot, such as upfront funding, making all clinical quality measures pay-for-reporting, and/or making adjustments to financial benchmarking policies, or increasing shared savings rates for those ACOs who pilot eCQM reporting.

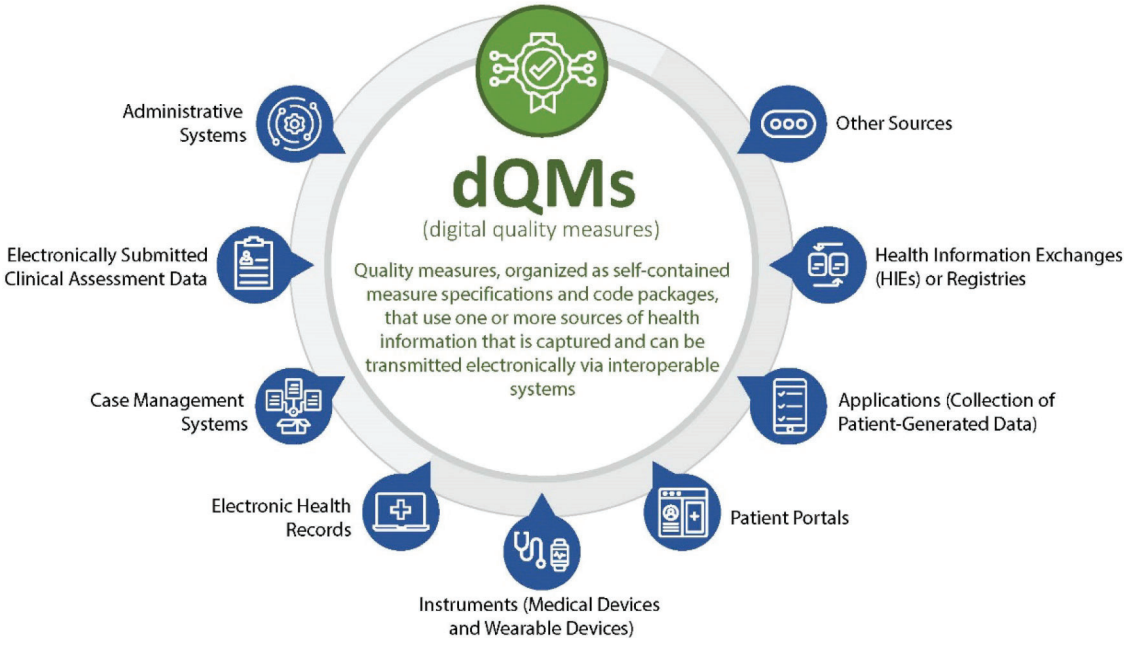
ACOs are acting now to prepare for the 2025 requirement to transition to eCQMs/MIPS CQMs. Many ACOs have interviewed vendors, who have quoted very high price tags to support this work. This work must be budgeted for future years, and it may redirect resources from clinically impactful patient care programs, as well as clinical engagement on those issues. CMS must work with ACOs now to establish a small pilot to allow the agency to continue to learn and advance the digital quality measurement future with the help of the most advanced ACOs in this area without harming the program by moving forward with an MSSP-wide program requirement. NAACOS looks forward to working with CMS.

Background

The recently released Centers for Medicare and Medicaid Services (CMS) National Quality Strategy and Digital Quality Measure Strategic Roadmap include goals to transition CMS quality program measures to digital quality measures (dQMs) in the near future. Through use of dQMs, CMS aims to facilitate more real-time exchange of quality data to further improvement goals and better support clinicians in providing care to patients, while reducing administrative burdens and costs associated with quality reporting. Accountable Care Organizations (ACOs) support the move toward increased use of digital information but have found the transition to dQMs, and electronic clinical quality measures (eCQMs) in particular, to be challenging and costly to implement, due to variation in electronic health records (EHRs) such as the differing methods for collecting and storing health information within the EHR, among other technical issues. Further, certain policy issues related to eCQM reporting raise additional concerns, chief among them the all-payer requirement associated with both eCQM and Merit-based Incentive Payment System (MIPS) Clinical Quality Measures (CQM) reporting methods. The all-payer requirement introduces an enormous amount of complexity in aggregating and de-duplicating data and expands the denominator for each measure dramatically with the potential to provide inaccurate assessments of the quality of care delivered by ACOs, as discussed further in this paper.

CMS defines dQMs as quality measures organized as self-contained measure specifications and code packages that use one or more sources of health information that are captured and can be transmitted electronically via interoperable systems. This includes data sources such as EHR data, patient-generated health data, registry data, and lab data among others. CMS's goal to transition its programs to rely on digital measures imagines this future state would focus on using standardized data, specifically by relying on Fast Healthcare Interoperability Resources (FHIR) standards, United States Core Data for Interoperability (USCDI) and supplemental standards (USCDI+ and other avenues such as implementation guides) that enable more automated extraction and transmission of EHR data for quality measure calculation and reporting.

Figure of dQM components, found on p. 5 of the CMS Digital Strategic Roadmap

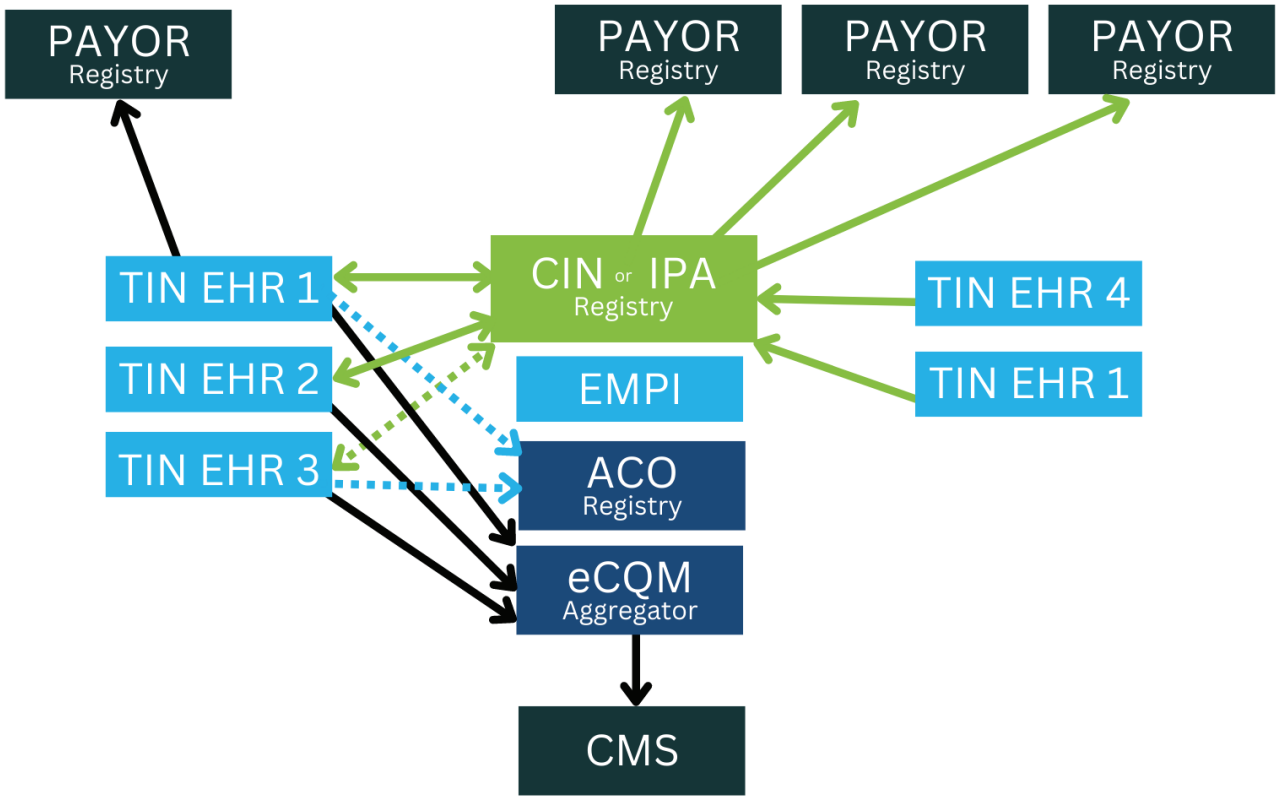


In a step toward achieving this goal, CMS recently finalized new requirements for ACOs to use eCQMs starting in 2025. To do this work, ACOs must de-duplicate patient data and then report aggregated data across all of their participant Tax Identification Numbers (TINs) to ensure the quality information shared with CMS is accurate and valid. ACOs bring together health care providers such as hospitals and physician practices across the continuum of care to better coordinate patient care to improve quality and decrease unnecessary health care costs. Because ACOs can consist of both hospitals and physician practices, as well as Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) which all rely on disparate EHR systems and instances of EHR systems, the work of aggregating patient data across the ACO is extremely complex, time consuming, and costly. Given the complexity and challenges of this work, the National Association of ACOs (NAACOS) convened a Digital Quality Measurement Task Force (Task Force) to identify technical obstacles that must be addressed to ensure a successful transition to eCQMs for ACOs and to outline key policy recommendations for how to solve remaining issues for ACOs. These recommendations will also assist in answering many of the future questions that other providers and CMS will encounter as they transition to dQMs.

This policy paper reviews the issues identified by the Task Force as impediments to transitioning to eCQMs and MIPS CQMs, as well as policy recommendations for CMS, the Office of the National Coordinator for Health IT (ONC), EHR vendors, and other key stakeholders to ensure a successful transition to eCQMs for ACOs that are aligned with the dQM future CMS is currently striving toward. These issues highlight some of the key challenges CMS will face as the agency embarks on its journey to move fully to dQMs for the various CMS quality programs in the future.

Finally, this paper does not include discussions regarding the Medicare Shared Savings Program (MSSP) ACO quality measure set or new quality scoring methodologies CMS recently implemented, but it rather focuses only on the implications of the transition to eCQMs/MIPS CQMs and digital quality measurement. More information about NAACOS advocacy efforts on quality scoring issues is available on our website.

Example of data transfer complexities needed for a large, multi-TIN ACO reporting eCQMs



Introduction

ACOs are evaluated on a number of quality measures, which allows CMS to assess the quality of care being provided to patients served by ACOs. These quality evaluations also determine whether an ACO is eligible to keep a portion of any financial savings it may generate, which is shared with CMS. Since the MSSP's inception, ACOs reported quality measures using a tool called the Web Interface. This tool provides a sample of assigned ACO patients on which the ACO reports quality measure data to CMS. The process requires manual abstraction of medical charts and allows for a straightforward and accurate way of reporting patient quality information to CMS.

Comparing Web Interface, eCQM and MIPS CQM Reporting Characteristics

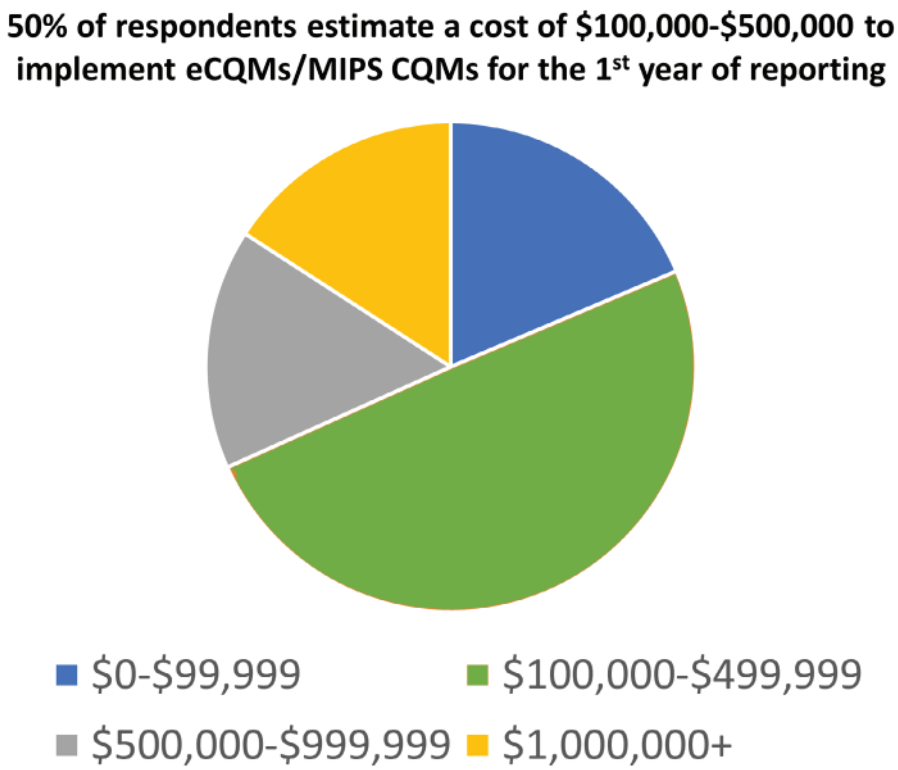
	Web Interface	eCQM	MIPS CQM
Patient population	Medicare	All payer	All payer
Eligible population (meet the denominator criteria)	Beneficiaries assigned to the ACO	All patients	All patients
Required sample size	Minimum of 248 consecutive Medicare beneficiaries Minimum of 70% of the eligible population	Minimum of 70% of the eligible population	Minimum of 70% of the eligible population
Data sources	Manual chart abstraction	Electronic health records extraction — no abstraction/ manual manipulation or supplementation permitted	Flat files, registry, EHR + abstraction permitted

In the final 2022 Medicare Physician Fee Schedule (MPFS) rule, CMS included a new requirement for all MSSP ACOs to report via eCQM or MIPS CQMs starting in 2025, when the agency will retire the use of the Web Interface reporting tool. In reporting eCQMs to CMS, ACOs will be required to report from their EHR(s), one aggregate Quality Reporting Document Architecture (QRDA) III file to CMS. This will require ACOs, either on their own or with the support of a vendor, to aggregate and de-duplicate patient data across all EHRs, across all ACO participants. ACOs will need to map quality data within each EHR to collect the appropriate information required for each measure in the appropriate location(s) in the EHR and may require additional clinical workflow changes to ensure clinical staff are capturing the right data in the correct place in the EHR in order to get credit for the measure. This is in contrast to the previous method of reporting, the Web Interface, which allowed ACOs to include information documented in varying places in the medical record using manual abstraction. Using MIPS #236, Controlling High Blood Pressure as an example, if the most recent blood pressure value was captured via remote patient monitoring and the result was documented by the clinician in a narrative note, an ACO would be able to identify and use this information when reporting via the Web Interface. During this shift

to eCQMs, ACOs will need to work with individual clinicians and practices to modify their workflows to ensure that these same values would be documented in a discrete data field. Otherwise, they will be unable to extract the most recent blood pressure value, leading to missing or invalid data.

Due to the complexity of completing these tasks across varying EHRs and practices, the validity and accuracy of data collection is difficult, and importantly, ACOs fear this shift will result in assessing how well documentation in the EHR was performed rather than evaluating the true quality of care provided to patients. This is particularly true for those whose clinical practice is far outside the scope of the eCQM measures such as the depression screening and follow-up/management measure, for a dermatologist who would then need to work the screening and follow-up into the workflow. In addition, ACOs will need to de-duplicate patient data found multiple times within and across the EHR(s) before submitting quality data to CMS. To date, CMS has suggested that ACOs can best achieve this goal by collecting QRDA I files, which contain patient level information, to de-duplicate where the same patient is counted across multiple EHRs, and then aggregate the data and submit one QRDA III file, which is an aggregate level quality report. This process is extremely complex and can take thousands of hours to complete. These burdens are exacerbated by the fact that eCQM/MIPS CQM reporting requires capturing data on all patients meeting the quality measure criteria, regardless of payer or whether the patient is an ACO-assigned patient. This includes reporting on exponentially more patients than was previously the case.

The burdens associated with reporting eCQMs/MIPS CQMs are not insignificant; some ACOs have been quoted over $1 million to do this work with the support of vendors and internal staff. In a recent NAACOS survey, 50 percent of respondents reported the work to transition to eCQMs for the first year of reporting would cost $100,000 to $499,000, 16 percent reported a cost of $500,000 to $999,999, and 16 percent reported costs over $1 million. As CMS considers moving forward with the eCQM requirement for ACOs, as well as the strategy to move all quality program measures to dQMs in the future, it is imperative that these costs and burdens are recognized and appropriate solutions provided to ACOs and their participant hospitals and physician practices to ensure a successful transition.



As ACOs are all structured differently, the challenges ACOs may have transitioning to eCQMs will also look very different. For example, the challenges for a single TIN ACO entity with all providers on the same EHR will be very different than the challenges for an ACO comprised of 30 TINs, each on a separate EHR and/or instance of an EHR. Additionally, some ACOs are comprised of both employed and independent providers, some include hospitals while others do not, and some are heavily comprised of specialty care providers. These differences present different challenges for each ACO.

While MIPS CQM reporting can provide the benefit of adding data that may not be captured in the appropriate place in the EHR through the addition of manual abstraction, many of the same barriers and challenges to reporting aggregate ACO data exist. Aggregating the data across multiple TINs and EHRs for all-payer data will still require significant resources for ACOs and is extremely complex work. For most ACOs, reporting via MIPS CQMs would require the support of a vendor outside that of their EHR vendor, thereby adding additional costs. Further, reporting in this manner does not bring the ACO any closer to the digital quality future that CMS envisions as it often includes transferring flat files and adding supplemental data beyond that of the EHR data. Because MIPS CQMs are more similar to the Web Interface, financed by ACOs through the use of additional registries/vendor support, and are not comparable to the eCQMs or dQM future CMS is implementing in early phases now, this paper does not focus on this reporting option, and NAACOS does not recommend this as a viable strategy for the majority of its members.

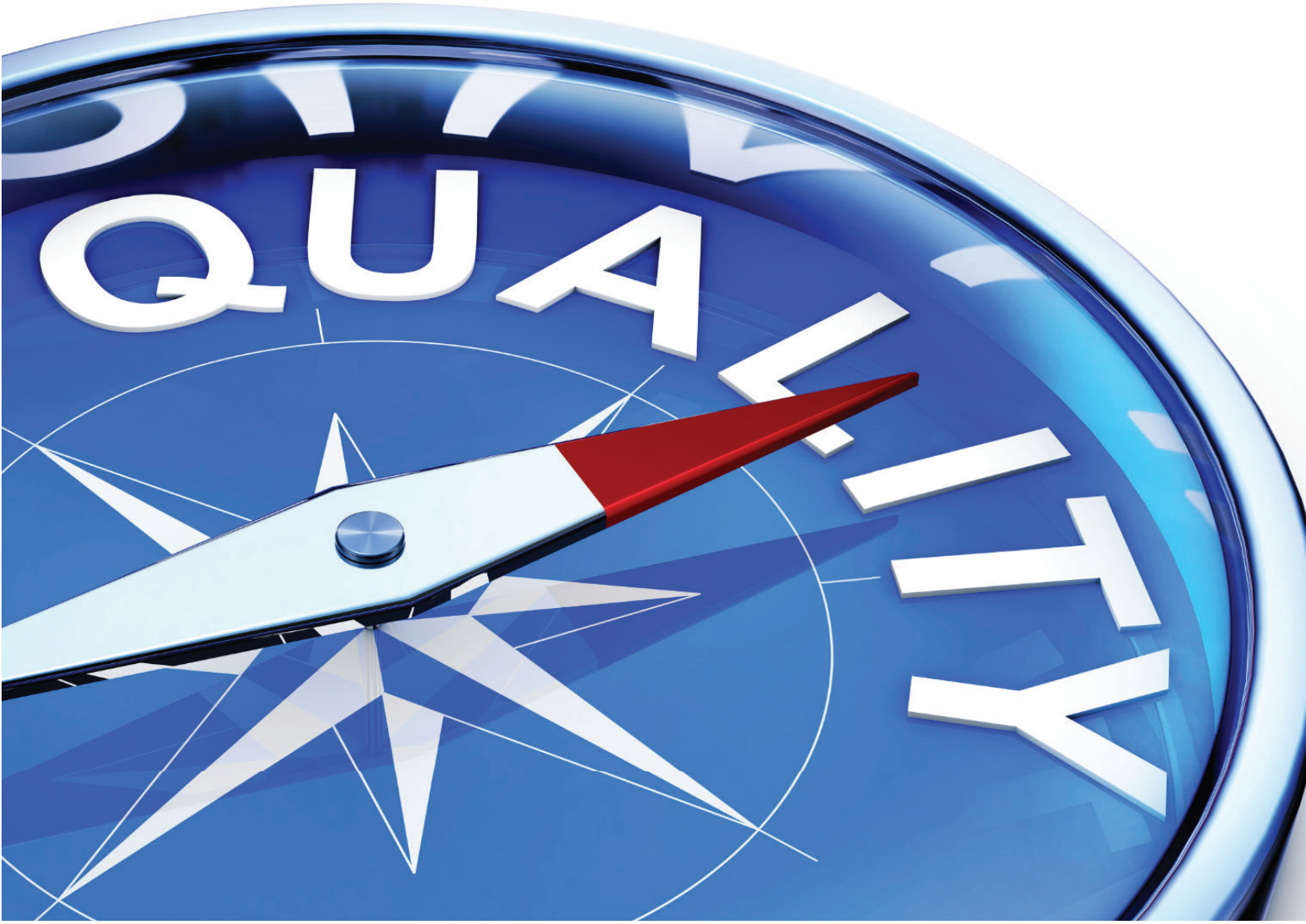
Finally, as CMS and ONC consider the use of FHIR-based APIs to support digital quality measurement, the agency is moving forward with a broader strategy that is disconnected from the eCQM/MIPS CQM requirements it is placing on ACOs to implement now, in preparation for the 2025 deadline. ACOs who invest significant resources to transition to eCQMs/MIPS CQMs may need to re-invest in the future to enable FHIR-based APIs.

Barriers and Potential Solutions/ Actions for Stakeholders

The goal of transitioning quality measurement to one that leverages standardized, bi-directional digital data available at the point of care with minimal administrative burden is laudable and one that ACOs support. In future years, when the transmission of data is seamless across providers and settings, data from multiple sources has the potential to further inform care decisions with patients and lead to the shared goal of improving patient outcomes. In an effort to assist in identifying potential barriers to this successful shift to dQMs and eCQMs and provide potential solutions, this Task Force identified some of the key challenges that must be quickly addressed before these goals can be realized. Many of these challenges are inter-related, and each, if not addressed, could lead to negative unintended consequences such as inaccurate representations of ACO performance.

I. CMS must not move forward with the all-payer requirement for eCQMs and MIPS CQMs when applied at the ACO level.

The all-payer requirement also exponentially broadens the patients an ACO will be assessed on, introducing new challenges and adding significant data extraction costs for ACOs as well as measurement validity concerns and privacy issues. Specifically, this is no longer limited to a sample of the Medicare-assigned beneficiaries for ACOs, but rather all patients meeting the eligible population criteria, regardless of whether the patient is an ACO-assigned patient or who the payer is. It is possible that participating practices may have to bear the burden of the data mapping, extracting, and reporting to the ACO due to contractual and legal issues of an ACO accessing data for individuals who are not within the ACO. This additional burden may lead to reductions in the number of practices with which an ACO has an established relationship. Further, this requires the ACO to demand access to certain quality data for patients with whom the ACO has no contractual relationship, which can raise privacy concerns. ACOs continue to find it challenging to be responsive to the request for all-payer data due to data availability. This specifically relates to the need for ACOs to track patients and their care when they have no direct relationship to the ACO. There is the potential for some ACOs to consider dropping certain TINs from their ACO, while at the same time certain TINs may choose to leave the ACO to avoid burdensome and costly new quality reporting requirements.



Additionally, because quality measure data will now include all patients who receive care from a participating TIN, it is very likely that the performance score attributed to an ACO will include variations in care delivery and achievement of outcomes that are due to patient access to care, insurance coverage, and/or medical complexity rather than the quality of care being provided. For example, many ACOs have relationships with FQHCs to provide care to their assigned beneficiaries. FQHCs provide care to a broader population that may or may not have access to the same services and interventions offered by the ACO and often to individuals with multiple risk factors such as food insecurity, housing instability, lack of transportation, lack of health insurance coverage or increased medical complexity. As a result, performance on the quality measures could be skewed based on inequities and differences in patient mix. This misrepresentation does not serve to drive change in a meaningful and useful way and would penalize ACOs and ACO participant TINs treating more vulnerable populations. Instead, CMS should strive to create new policies that drive improvement in this area. The recently released health equity bonus points included in the 2023 proposed MPFS rule to apply to ACOs reporting eCQMs or MIPS CQMs would not solve this problem and more should be done by CMS. NAACOS has provided detailed policy recommendations on this topic and urges CMS to consider innovative ways to encourage ACOs to address health inequities.

Additionally, the Web Interface measures assess ACOs on a sample of ACO assigned patients, with the assignment methodology relying heavily on primary care services. The expansion to a broader eligible patient population beyond just ACO-assigned beneficiaries will lead to a specialist participating with an ACO being attributed as eligible for a measure denominator for a clinical service intervention that is outside of the typical scope and practice of that clinician. Certain specialists may consider it clinically inappropriate for them to take steps to meet the primary care quality measure if the measure and its related care are outside of their professional focus. For example, if a patient has an annual skin cancer screening and a diagnosis of diabetes is also captured in the medical record, then MIPS#001, Diabetes: Hemoglobin A1c (HbA1c) Poor Control will be attributed to the dermatologist, and the ACO will be required to include this patient in the measure denominator. This broader attribution could lead to the inclusion of patients who receive care with only a portion of the clinicians with which the ACO has an established relationship. In the example above, if this same patient receives primary and specialty care from practices within the ACO's network of practices, then they will likely be able to identify the most recent A1c through the primary care visit. If on the other hand, the patient's primary care clinician does not have a relationship with the ACO, then there is the potential for the HbA1c to either be missing since it resides within a different location/EHR or someone may repeat the test to ensure compliance with the measure. Requiring specialists to collect additional data and/or provide additional services outside of their usual scope of work could also serve as a distraction and negatively impact care delivery. In addition, this expansion will have a negative effect on performance scores of ACOs with higher proportions of specialty practices. While MIPS clinicians reporting eCQMs and MIPS CQMs have been assessed on all-payer data since the start of the program, these clinicians have had the freedom to select the measures they report on, while ACOs do not have the flexibility to select measures that will not be as broadly applicable.

The denominator expansion caused by the all-payer requirement creates additional challenges, including increasing the complexity to ensure that the data elements extracted are valid, meaning that the correct data elements for the specified timeframe are identified across the multiple visits a qualifying patient has with often more than one clinician and practice. ACOs have started to examine the potential impact this shift to eCQMs and the expansion of the denominator to a broader set of patients will have on performance scores. Table 1 compares eCQM scores to Web Interface scores for the same set of measures, looking at 2021 performance data for a single TIN ACO with one EHR. This example shows the wide variation that exists, only when changing

the reporting method. These differences in no way indicate that any lower standard of care was provided to a patient, but rather that the clinical documentation was not mapped within the EHR in a way that would result in the same level of performance when calculating the measure score. This variation exists despite the fact that the ACO is a single TIN and single EHR ACO. This problem is further exacerbated when looking at a practice with a high proportion of specialty providers, as shown in Table 2. This emphasizes the issues with comparing performance results across ACOs with varying reporting methods.

Table 1: Comparing eCQM to Web Interface Scores for a Single TIN ACO with One EHR

Quality Measure	eCQM Score	Web Interface Score
Depression Screening and Follow-Up	0.00%	31.58%
Diabetes: HbA1c Poor Control	12.47%	5.32%
Controlling High Blood Pressure	85.68%	88.84%

Table 2: Comparing eCQM to Web Interface Scores for a Multi-TIN ACO with Multiple EHRs

Quality Measure	eCQM Score	Web Interface Score
Depression Screening and Follow-Up	50%	86%
Diabetes: HbA1c Poor Control	22%	6%
Controlling High Blood Pressure	65%	70%

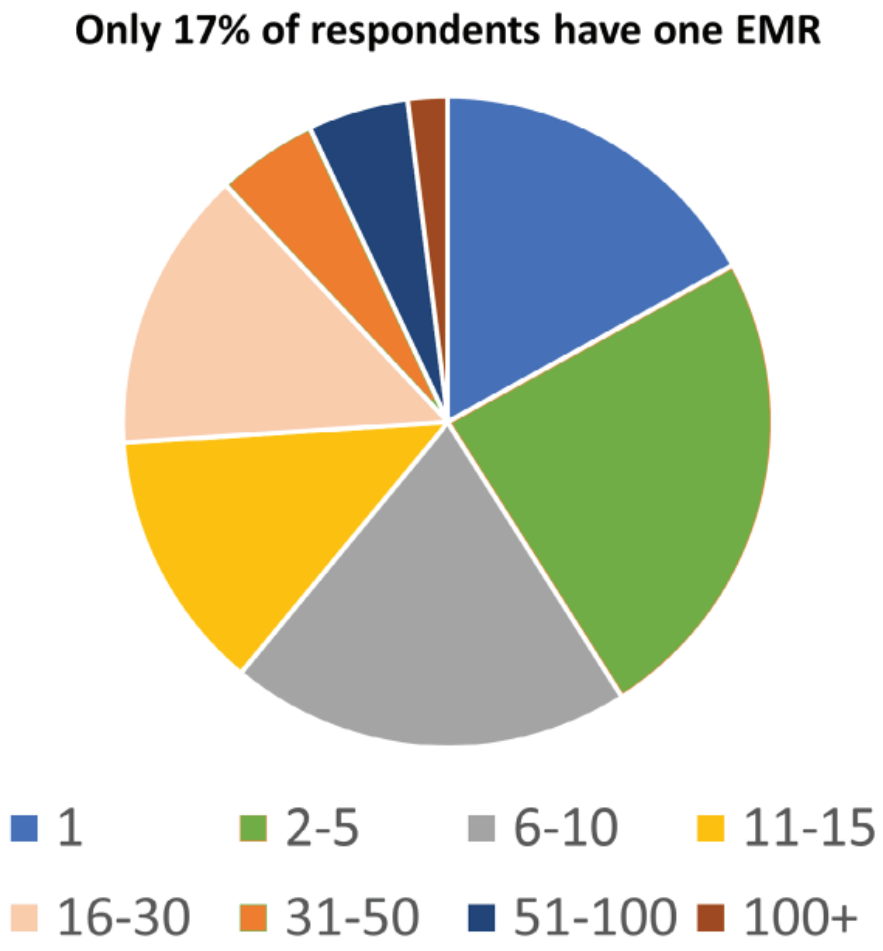
Solutions

As discussed above, there are many issues arising from the expansion to all-payer data associated with the eCQM requirement for ACOs. Given the complexity and potential unintended consequences, CMS must ensure all-payer performance data is not used for determining ACO payments. Measuring performance on all-payer data results in ACOs being measured not on clinical quality of care provided, but rather the composition of the ACO and the payer mix. If CMS does not remove this requirement, CMS should consider alternatives such as relying on all attributed ACO patient data or applying a different attribution approach that is less broadly applicable (e.g., exclude specialists in a way similar to what is done for the MIPS cost measures). While eCQM reporting makes it technically difficult to separate performance by payer, it is still imperative that CMS explore ways to address this issue as it is not an appropriate comparison to assess all-payer data.

II. EHR certification criteria must support ACOs in what they are required to achieve for electronic clinical quality and digital quality measurement.

ACOs will need to be able to collect and report data from multiple practices and EHR vendors across all of its ACO participant TINs. A recent survey of the NAACOS membership found that only 17 percent of respondents use one EHR, 24 percent use two-to-five different EHRs, and 20 percent use between six and 10 different EHRs. While CMS and others often assume that EHR vendor systems with 2015 Certified Electronic Health Record Technology (CEHRT) would automatically include the capability to easily report the most recent version of an eCQM for MIPS with minimal manual effort, that is not the case. The CEHRT requirements do not standardize the capture and reporting of individual eCQM data elements across vendor systems, and ACOs will still need to tailor data extracts and uploads across systems and participating TINs. Additionally, not all CEHRT vendors will implement every eCQM potentially leaving a gap for ACOs.

Because the current CEHRT requirements are not sufficient to enable successful reporting of eCQMs at the ACO level, it will be necessary for vendors to meet additional conditions to enable a successful transition to eCQMs, and ultimately dQMs.



Solutions

As CMS considers solutions to these problems, there must be a realization that there are shorter-term needs and potential policy solutions as well as a longer-term, future state goal for interoperability and sharing of digital quality data. As ACOs attempt to achieve CMS's goal without the proper tools in place, this intermediate step of shifting to eCQM reporting will be highly costly and burdensome. Not all ACOs will be able to afford the changes necessary to be successful in this intermediate phase of work; therefore, CMS must consider first implementing a proof-of-concept test with ACOs who are able to make these investments and reward them for that work through incentives. Additionally, appropriate exceptions and exclusions must be incorporated to address areas where the technology is not yet supporting the goals CMS hopes to achieve.

Table 3 outlines the minimum conditions to meet current requirements for ACOs to be successful in eCQM reporting in the short-term. Table 4 outlines the business requirements for the longer-term/future state CMS hopes to achieve. These recommendations include requirements that the ONC would include in CEHRT criteria for vendors to better support ACOs in this work. The table also outlines additional capabilities and support around data/value set mapping as well as collection of QRDA I files to better support accurate patient matching. It is critical that underlying certification criteria support ACOs in what they are required by CMS to achieve for eCQM reporting. To date, these requirements are not consistently met or required of vendors via certification criteria.

Table 3: Minimum Conditions to Meet Current Requirements for ACOs to be Successful in eCQM Reporting

Capability	Details	Scope of Requirement
Produce eCQMs	❑ View eCQM performance in easily accessed dashboard ❑ Tool to drilldown to patient level to understand and validate outcome calculation ❑ Generate QRDA I and QRDA III files for all requisite MIPS eCQMs ❑ Complete data/value set mapping within EHR ❑ Create utility to identify gaps in mapping ❑ Enable practice customization to account for unique workflows ❑ Update measure specifications to reflect annual rulemaking. Changes should be made available via software updates for health systems/practices on earlier versions of the EHR. Development timeframe and implementation estimates should be publicly posted.	All vendors – Part of CEHRT
Transfer of eCQMs between disparate EHRs	❑ Facilitate secure exchange of eCQM QRDA I files from one EHR to another ❑ Ensure ingestion of QRDA I files into "base EMR" does not compromise patient data or negatively impact system performance ❑ Additional requirements exist if disparate EHRs utilize FHIR to facilitate exchange	Any EHR vendor that seeks demarcation as ACO reporting compliant
Aggregation & Deduplication	❑ Must facilitate/accommodate patient matching (<10% error rate) ❑ Ability to remove duplicate patients per measure specifications ❑ Construct ACO-level summary	

Table 4: Future State Business Requirements for ACOs to be Successful in eCQM Reporting

Capability	Details	Scope of Requirement
Produce eCQMs	❑ View eCQM performance in easily accessed dashboard ❑ Tool to drill-down to patient level to validate/understand outcome calculation ❑ Complete data/value set mapping within EHR ❑ Create utility to identify gaps in mapping ❑ Enable practice customization to account for unique workflows ❑ Update measure specifications to reflect annual rulemaking. Changes should be made available via software updates for health systems/practices on earlier versions of the EHR. Development timeframe and implementation estimates should be publicly posted.	All vendors – Part of CEHRT
Transfer of eCQMs between disparate EHRs	❑ Facilitate secure exchange of data underlying eCQMs/dQMs from one EHR to another ❑ Enable mapping requisite for utilization of FHIR (assist automatic transfer of mapping completed for eCQMs to future state FHIR)	
Aggregation & Deduplication	❑ Ensure ingestion of eCQM data into "base EHR" does not compromise patient data or negatively impact system performance ❑ Must facilitate/accommodate patient matching (<10% error rate) ❑ Ability to remove duplicate patients per measure specifications ❑ Construct ACO-level summary	Any EHR vendor that seeks demarcation as ACO reporting compliant

III. CMS must identify an alternative pathway to transmit data in a standardized way to enable successful patient matching, such as use of a national patient identifier or revisions to QRDA I formats.

Based on the current requirements for ACO reporting of eCQMs and MIPS CQMs, ACOs must be able to de-duplicate data across multiple practices to create the single data file for each patient necessary for each measure. These data would be generated using QRDA I files (patient-level), and then once patients are matched, the QRDA III file (aggregate at the ACO level) can be created and submitted to CMS. In the absence of a national patient identifier, ACOs must find solutions to enable this patient matching.

To date, there has been limited to no experience on patient matching by MIPS third party intermediaries (e.g., qualified registries, Qualified Clinical Data Registries [QCDRs], health information technology [HIT] vendors) since the vast majority of MIPS participants report using a single National Provider Identifier (NPI) or TIN. While other groups such as health information exchanges (HIEs) may have some experience, ACOs report that the volume of patients and records with which these organizations have worked are significantly less than the thousands of patients and records that ACOs must collect and de-duplicate to achieve the desired goal of a single data file for each patient. It is not unusual for an ACO to include thousands of providers rendering millions of encounters annually. After applying automated matching algorithms on available data, this still results in many thousands of records requiring manual review prior to aggregation. Furthermore, while claims files on attributable beneficiaries provide highly useful data to assist with this process, those are not available for the all-payer all-patient population (i.e., the majority of the care).

In addition, as ACOs began to explore what individual patient identifiers (e.g., full name, date of birth, address) would be required to enable this matching, it became increasingly clear that the current structure of the QRDA I file will not provide the data necessary to do accurate patient matching. As a result, ACOs will need to implement other solutions to allow them to collect the required data fields and document the processes and procedures used.

It should also be recognized that initial efforts to match patients may yield less than desirable results and this will directly impact the validity of the eCQM results and, if used for other purposes, could adversely impact patient records and compromise patient safety. While ACOs, their vendors, and others will be able to improve the accuracy of matching, it will be necessary to accept lower rates of performance until experience is gained. During that time, CMS and others should view the measure results with caution given the potential impact to the validity of the data and measure results and reconsider whether the resulting data should be used for payment or public reporting if the matching approach does not achieve a certain accuracy level. It should be noted that some ACOs, for example an ACO with one TIN, one EHR, and a large portion of the market, may have fewer issues with patient de-duplication. However, even for an ACO with a single TIN and single EHR, this is still complex work. Further, we know that the majority of ACOs are comprised of more than one TIN.

Solutions

Potential solutions CMS could provide include developing additional guidance and standards for ACOs regarding how CMS expects patient matching to be completed. CMS should also consider revisions to QRDA I, such as adding more demographic fields, or find an alternative pathway by which data can be transmitted in a standardized way to enable successful patient matching. We note that while there appears to be little political will to implement a national patient identifier, the creation of such an identifier would solve many of the problems

that exist for patient matching today. Finally, CMS should also provide additional guidance on what the rate of accuracy in patient matching is expected to be and provide ACOs sufficient time to refine their processes and procedures to meet that rate. If CMS should assess eCQM performance/require reporting for attributable MSSP patients for whom claims files can provide and additional matching anchor, this would address these problems to a large extent.

IV. CMS must provide the industry with greater standardization of data to assist in the highly burdensome process of data mapping and other workflow changes that will be necessary to transition to eCQMs and dQMs.

It is often assumed that moving away from the Web Interface, which requires manual abstraction, and to eCQMs will remove all or most administrative burdens associated with quality reporting. However, there are still administrative burdens associated with the use of eCQMs. One such burden is that of workflow changes that are required to ensure the appropriate information is captured in the appropriate location within the EHR. These burdens fall directly on clinical staff already overburdened by administrative issues and are significantly higher than those associated with a sample-limited annual data reporting effort like the Web Interface. For example, MIPS #134, Preventive Care and Screening: Screening for Depression and Follow-Up Plan, allows different screening tools based on the patient's age and provides multiple options by which the follow-up plan can be met, such as referrals and pharmacological interventions. While ideally these data are captured using clinical workflows that are well integrated into patient care to minimize documentation burden, ACOs must ensure that clinical staff are aware of what screening tools and interventions are captured within the EHR as well as from what fields the ACO intends to extract this information. Otherwise, there is a real risk for clinical interventions to be captured outside of extractable fields, resulting in inaccurate and invalid representations on the quality of care provided.

Solutions

CMS must recognize these burdens as it considers changes to measure sets and must work to create stability in the programs to minimize the need for constant changes. Additionally, CMS must accelerate the rate of standardization of the individual data elements required in an eCQM. Therefore, CMS must accelerate the rate of adoption for EHRs to have the individual data elements required in an eCQM. Specifically, while we do not believe that requiring specificity on where the data elements are located across all EHRs is desirable, it is imperative that we achieve a vocabulary (including definitions and standardized value sets) that are shared across all settings including those devices outside of the traditional EHR that are capturing eCQM data elements. This approach will promote alignment of the data used by various payers, vendors and clinicians across programs and ideally reduce the workflow changes that will be necessary as measures are updated and/or added. Using the same measure (MIPS #134), the attributes, definitions, and value sets for each data element would be precisely defined with vendors required to integrate this information into each EHR instance. ACOs would then be able to map existing discrete fields to these requirements and standardize the clinical workflows used across the participating practices to ensure accurate and complete extraction of these data for each eCQM. Finally, any requirements CMS places on ACOs now should be connected to requirements ACOs will be expected to meet in the future for dQM reporting, such as through FHIR-based APIs.

V. CMS should allow for alternative data completeness standards for ACOs reporting eCQMs or allow for exceptions/exclusions.

Currently through the Web Interface tool, ACOs spend significant time and effort to ensure that the data submitted to CMS accurately reflects the quality of care provided to ACO beneficiaries. Dedicated staff comb through patient records to ensure that the right data for the right time period are identified and included in the measure calculations. While the current process uses a sampling methodology, the shift to eCQMs and MIPS CQMs requires that ACOs submit data on 70 percent of all patients who receive care from an ACO participating practice. This expands the denominator dramatically. CMS should consider the goals of data completeness requirements for ACOs reporting eCQMs.

In addition, the new requirements stipulate ACOs must include a broader set of patient data. Specifically, ACOs must identify all patients, regardless of whether they are one of the ACO's Medicare-assigned beneficiaries, to whom a measure's denominator applies. This expansion will require some form of manual abstraction and validation of the data until more automated methods are available. Identifying the entire potential patient population to which a specific measure will apply also increases the chance for inadvertent errors where ACOs may not achieve the necessary 70 percent data completeness requirement. These omissions will not be due to the desire to "cherry pick" or "game the system" but rather will likely reflect the inability of practices and EHR vendor systems to readily produce reports that will provide the necessary data to identify the eligible population.

Solutions

CMS should instead consider alternative data completeness standards for ACOs. As an example, CMS could require a lower data completeness standard for ACOs or base data completeness not on patients but practices within the ACO (i.e., ACOs would demonstrate they were able to collect and aggregate data across 70 percent of participant practices). Alternatively, CMS could allow for exceptions/exclusions for certain practices within the ACO, such as small practices and/or certain specialty practices. These could align with current small practice exemptions used in the MIPS program. Lastly, CMS could consider removing data completeness requirements for ACOs until or unless the validation process becomes more automated.

Ensuring that the patient matching/de-duplication process and resulting data are valid should not be solely considered the responsibility of the ACOs. Similar to how qualified registries and qualified clinical data registries (QCDR) must submit the results of their validation plans, CMS should expand this requirement to all third-party intermediaries including HIT vendors and include not only confirming the accuracy of the quality data but also ensuring the desired accuracy for patient matching.

VI. CMS should provide policy incentives to help offset the enormous initial and ongoing costs associated with transitioning to eCQMs and dQMs, including making clinical quality measures pay-for-reporting, ensuring shared savings are not at risk, and/or setting alternative financial benchmarks for those who voluntarily test eCQM and dQM reporting.

While the goals of moving to more digital quality measures are laudable, the costs and administrative burdens that are being placed on ACOs must also be acknowledged. These costs and additional staff time are significant and are not being funded or supported in any way by CMS or other stakeholders. They will affect not only ACOs but also the many participant practices that engage with ACOs, some of which are small, rural, independent, or serving a large portion of under resourced areas. CMS must consider who should bear the burden of these costs in the goal of moving to fully interoperable, digital quality data and acknowledge there may be unintended consequences of placing those cost burdens solely on ACOs and their participant practices.

NAACOS recently surveyed its membership to better understand the burdens and costs associated with the transition to eCQM reporting. This survey was a follow-up to a previous survey conducted in 2021. Though ACOs have continued to learn more about the policies CMS instituted for eCQMs over the last year, the results of this follow-up survey are similar to those of 2021. The survey had 173 responses and shows there are varying levels of readiness across ACOs with 62 percent of respondents reporting that they will not be able to report or are unsure if they will be able to report eCQMs by the 2025 required deadline. This is a very high level of uncertainty.

As stated above, there are also significant costs associated with the transition to eCQM reporting for those who have already identified a path forward. Fifty percent of respondents reported the work to transition to eCQMs or MIPS CQMs for the first year of reporting would cost $100,000 to $499,000, 16 percent reported a cost of $500,000 to $999,999, and 16 percent reported costs over $1 million. This $1 million investment to report on just three clinical quality measures could instead be used to fund the addition of nine care managers or six pharmacists to serve patients. Additionally, 40 percent of respondents noted they were not sure when they would be able to report eCQMs, suggesting that many ACOs are still in the early planning stages. For a small

ACO who has a single TIN and one EHR, the costs of reporting eCQMs may be lower though staff burden may be higher, while a large ACO with 50 TINs and 10 EHRs may have much higher costs associated with reporting eCQMs. As described above, this is largely due to the complications of aggregating data across disparate EHR systems and conducting patient de-duplication and data mapping.

The burdens associated with reporting eCQMs most cited were costs as well as workflow redesigns needed to capture clinical data in the correct place in the EHR in order to receive credit for the measure. These additional costs and burdens result from the need to support quality measurement for just three clinical quality measures and do not directly contribute to better patient care. This further emphasizes the need for a pilot before mandating eCQM reporting among all ACOs in the largest and most successful, permanent value program in Medicare. To ignore these costs and burdens could result in fewer ACOs participating in MSSP and/or fewer practices willing to participate in ACOs.

Solutions

CMS should consider providing grant funding to a certain number of ACOs willing to pilot eCQMs to help offset these initial and ongoing costs. As an example, the Health Resources and Services Administration (HRSA) provided grant funding to an FQHC to cover a vendor's support in transitioning to eCQMs/MIPS CQMs. Alternatively, CMS could provide certain policy incentives to help offset these costs. As an example, CMS could make all clinical quality measures pay-for-reporting for ACOs who elect to move to eCQM reporting to ensure their shared savings would not be at risk if they make the financial investments necessary to transition to eCQMs. CMS could also consider making alternative benchmarking policies for those ACOs who report eCQMs or increasing shared savings rates for those who pilot eCQM reporting.

VII. CMS must pilot use of both FHIR-based APIs and QRDA I/III reporting of eCQMs with a small number of willing ACOs before moving forward with a program-wide requirement.

In 2020, the Interoperability and Patient Access final rule and 21st Century Cures Act final rules were published with the goal of driving interoperability through complete access, exchange and use of all electronically accessible health information. These rules require certain health care providers and health plans to make a defined set of patient information available to authorized users including providers, health plans and patients, using FHIR APIs. The standards will evolve over time but will begin with data specified in the United States Core Data for Interoperability (USCDI) Version 1, structured according to the Health Level Seven International (HL7) FHIR U.S. Core Implementation Guide (U.S. Core IG). These standards will facilitate increased availability of structured, FHIR-formatted EHR data exchange through FHIR APIs. CMS hopes this will reduce administrative burdens associated with quality reporting and measurement currently, which requires providers to adapt their respective EHR systems. Unfortunately, the current eCQM reporting requirements only allow reporting of quality data using the QRDA data submission standard, which does not solve but rather contributes to the barriers with patient matching and data capture discussed above. In addition, ACOs will need to complete significant rework on how the data will be captured, matched, and transmitted, and they will likely encounter additional costs when CMS ultimately allows reporting of quality data using FHIR APIs.

Solutions

Given CMS and ONC efforts currently underway to transition to FHIR-based APIs to support quality measurement and reporting, it is not sensible to move forward with a program-wide implementation of eCQM/MIPS CQM requirement for ACOs. Given QRDA limitations and CMS's focus on the future of FHIR-based standards, it is logical for CMS to begin piloting use of FHIR-based APIs with a select number of ACOs. CMS could easily allow for this by including FHIR-based APIs as an acceptable standard for submitting quality data and testing through a limited pilot of eCQM reporting using QRDA and FHIR-based APIs with a small number of ACOs, such as 10 ACOs.

This further emphasizes the need for a small pilot of ACOs to test more digital quality measurement efforts including eCQMs and FHIR-based dQMs, before subjecting the largest alternative payment model (APM) — MSSP ACOs — to a requirement that may be soon obsolete.

Conclusions, Recommendations, and Next Steps

As CMS and ONC consider the future for digital quality measurement, the goal should be to improve how quality data can be captured to better support patient care at the point of care and appropriately reward high value care. NAACOS supports moving to more digital sources of quality measurement that would allow the bi-directional sharing of near real time quality data to improve patient care. However, CMS must use caution as they move toward this goal. CMS should engage stakeholders throughout the process to identify unintended consequences and to ensure goals and timelines are feasible. The transition to this dQM future must be iterative and build off of previous work and investments. If CMS envisions eCQM requirements for ACOs as an intermediary step toward this dQM future, any technology investments must build upon one another (i.e., CMS should not change direction in the next phase). Doing so would harm the value movement as these investments would be lost. Specifically, as CMS looks ahead to dQMs using FHIR-based APIs, the agency must consider how this will affect ACOs who will need to revise strategies and re-invest resources again to comply with new standards. Therefore, a more equitable approach in the current state is for CMS to first pilot eCQMs/MIPS CQMs for ACOs with a select number of willing participants before implementing program-wide requirements. In addition, CMS must provide strong incentives to those willing to participate in the pilot such as upfront funding, making all clinical quality measures pay-for-reporting, and/or making adjustments to financial benchmarking policies, or increasing shared savings rates for those ACOs who pilot eCQM reporting. Lastly, CMS must reconsider the inclusion of the all-payer requirement associated with eCQM reporting for ACOs. This introduces additional costs and complexities that do not contribute to or enable better patient care and, most importantly, may instead harm ACOs with large proportions of underserved patients as well as ACOs with a large number of specialists. ACOs should not be assessed on data for patients outside the ACO for purposes of program evaluations. If the all-payer requirement persists, CMS must at a minimum consider exceptions and exclusions for certain small, rural, and specialty practices to mitigate unintended consequences of penalizing ACOs based on factors other than quality of care provided.

CMS must quickly issue these recommended policy changes to avoid ACOs and/or participant practices in ACOs leaving the program. ACOs are acting now to prepare for the 2025 requirement to transition to eCQMs/MIPS

CQMs. Many ACOs have interviewed vendors who have quoted very high price tags to support this work. This work must be budgeted for future years, and it may redirect resources from clinically impactful patient care programs, as well as clinical engagement on those issues. CMS must work with ACOs now to establish a small pilot to allow the agency to continue to learn and advance the digital quality measurement future with the help of the most advanced ACOs in this area without harming the program by moving forward with an MSSP-wide program requirement. NAACOS looks forward to working with CMS on this issue to develop a sensible and equitable path forward to achieve CMS's digital quality measurement goals.

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The National Association of ACOs (NAACOS) represents more than 12 million beneficiary lives through hundreds of organizations participating in population health-focused payment and delivery models in Medicare, Medicaid, and commercial insurance. Models include the Medicare Shared Savings Program, Direct Contracting, and alternative payment models supported by a myriad of commercial health plans and Medicare Advantage. NAACOS is a member-led and member-owned nonprofit organization that works on behalf of health systems and physician provider organizations across the nation participating in population health-focused payment models to improve quality of care, outcomes, and health care cost efficiency.

Vision

- In collaboration with organizations and professionals who share our values, we work to improve population health, enhance patient experience, reduce cost to patients and tax payers, support care teams, and advance health care quality and equity.
- Specifically we strive to:
    - o Grow the number of individuals in accountable care relationships consistent with the national aim to have every Medicare beneficiary with a provider accountable for quality and total cost of care by 2030.
    - o Help our members to be high performing – formalizing education over time, being intentional in broadening the landscape of education to accountable care, and helping prepare tomorrow's accountable care leaders.
    - o Advocate and adapt as needed to ensure a sustainable and innovative accountable care landscape – influencing policy and other changes, driving innovation, communicating the value for patients in accountable care, and supporting ACOs and accountable care in Medicaid, Medicare Advantage, or commercial insurance.

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