ACO Quality Reporting Requirement Changes

Quality requirements are changing in 2025. To align Medicare Shared Savings Program (MSSP) quality with the Merit-Based Incentive Payment System (MIPS) approach, CMS has created a mandate for ACOs to transition to reporting via electronic clinical quality measures (eCQMs) or MIPS clinical quality measures (MIPS CQMs) by 2025. A roadmap for moving to digital quality measurement is needed; however, the new approach will add significant costs and burden for ACOs and will deter participation in the program. While CMS has proposed an interim solution to mitigate some of these concerns, if finalized, this would be a temporary fix and not solve the key issues in the long-term.

Key Challenges

eCQMs and MIPS CQMs require reporting and scoring on all patients, even non-ACO and non-Medicare patients

- This holds ACOs accountable for quality for patients that are not in the ACO. The ACO receives certain payment rule waivers and other flexibilities, but only for the Medicare ACO patients they serve. Holding ACOs accountable for patients outside their assigned panel of patients is unfair and inappropriate.
- The shift to all payer data will result in ACOs being measured not on the clinical quality of care provided, but rather the composition of the ACO and the ACO's payer mix. This will harm ACOs with large portions of underserved patients and specialists.

In a 2022 poll of NAACOS members, 50% 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. And 16% reported a cost of $500,000 to $999,999 – this is money that could have funded free mammograms, or new care coordinators for the ACO.

Aggregating data across multiple EHRs is complex and costly.

- Because ACOs must aggregate data across many practices; both independent and employed, large and small and on disparate EHRs; the data aggregation and patient de-duplication efforts to ensure accurate data is being reported to CMS are immense.
- Identifying unique patients across systems that do not talk to each other is challenging, time consuming and costly. The cost and burdens are being placed on ACOs. This is money that could otherwise be reinvested into patient care.
- Lack of interoperability is a key challenge – 2015 CEHRT requirements don't solve this problem. For a large group practice on one EHR, reporting via eCQM or MIPS CQM can be efficient and low burden. However, for ACOs aggregating data across many different provider types this is extremely complicated work. Simply being on 2015 edition CEHRT does not solve this problem – CEHRT requirements do not facilitate ACOs combining this quality data across EHRs.

Congress must work with CMS to ensure the agency does not move forward with new quality requirements before testing with a pilot.

- ✓ CMS must test reporting with a small number of ACOs representing varying sizes, types, and structures to solve the remaining implementation problems that exist. Otherwise, some ACOs may choose to leave the program altogether.
- ✓ While CMS proposals in the CY 2024 Medicare Physician Fee Schedule (MPFS) rule would provide an interim solution to mitigate these concerns, this is a time limited and temporary fix that does not solve the underlying concerns in the long-term.
- ✓ CMS should delay the 2025 requirement to transition to eCQMs or MIPS CQMs and first pilot these changes or make permanent solutions for the feasibility concerns ACOs have raised.

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