

NAACOS Feedback on Moving ACO Quality Reporting to eQMs and MIPS CQMs

Background: The National Association of Accountable Care Organizations (NAACOS) recently surveyed Medicare Shared Savings Program (MSSP) ACOs to collect feedback on the MSSP quality overhaul and to understand ACO readiness to shift from the Web Interface reporting option to electronic clinical quality measures (eQMs) and MIPS Clinical Quality Measures (CQMs). The quality overhaul was finalized in the final 2021 Medicare Physician Fee Schedule [rule](#), with some changes effective in 2021 and others being implemented starting in 2022. NAACOS shared feedback with CMS through our comment [letter](#) in response to the proposed rule and through meetings with agency staff. The MSSP quality survey was emailed in February to all MSSP ACOs, and there were 200 responses from 163 ACOs across the country, which represents a quarter of MSSP ACOs.

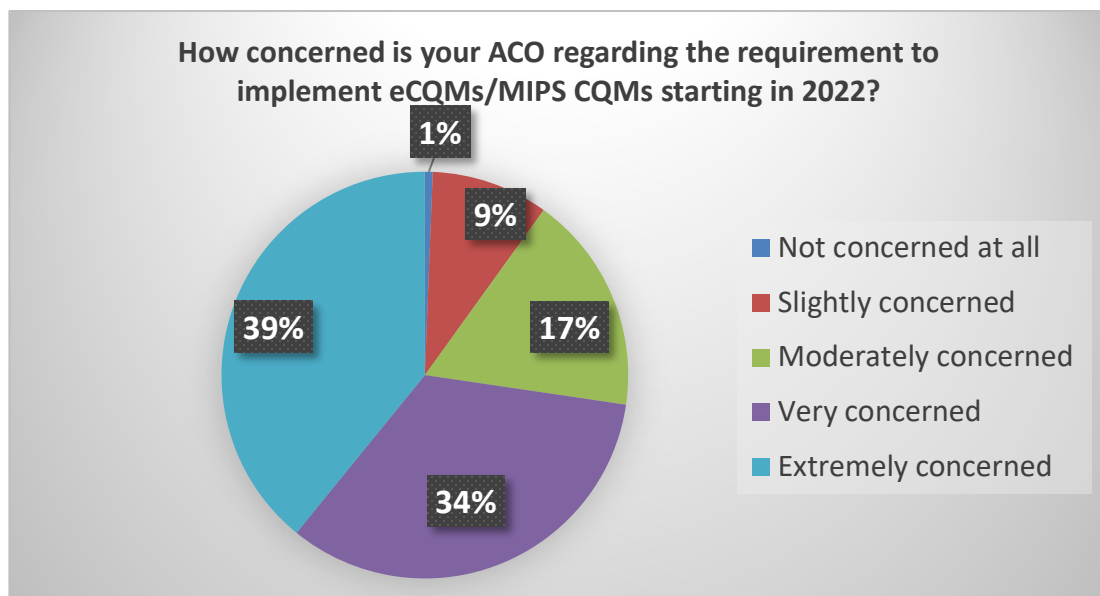
Recommended policy change: Based on the feedback obtained through the survey, as detailed below, ACOs and CMS are not sufficiently ready to move to eCQM or MIPS CQM reporting in 2022. There is a very concerning gap between the current state of ACO quality reporting and what is necessary to report these measures in nine short months. NAACOS urges CMS to delay implementation of mandatory ACO eCQM and MIPS CQM reporting until:

- the questions and concerns around access to all payer data are properly addressed;
- interoperability across electronic systems is widely available to enable the seamless transfer of data across providers and settings; and
- the shift to eQMs is supported by increased standardization of the required data elements and logic across electronic health record (EHR) vendor systems, to allow for robust real-world testing and assurance of reliable and valid measure results at the ACO level.

We also request that CMS work closely with ACO stakeholders to evaluate and identify a more appropriate quality reporting solution.

Overall level of concern

99% of ACO respondents report their ACO is concerned with the requirement to implement eQMs or MIPS CQMs in 2022. This level of concern, coupled with numerous outstanding implementation questions, illustrates how important it is for CMS to take swift action to abandon, or at least delay, the transition to eQMs and MIPS CQMs.



Current state of readiness

Current ACO reporting on quality measures:

- Targets those beneficiaries who are directly attributed to the ACO;
- Requires data collection and reporting on a sample of patients; and

- Allows flexibility in how data are captured by the ACO including manual data collection, electronic data sources, or a hybrid approach.

Impediments to the shift to eQMs and MIPS CQMs across all payers

ACOs recognize there are long-term benefits of reduced manual chart abstractions and reporting, but they anticipate several notable barriers, which outweigh those benefits. The top three barriers identified by survey respondents include:

- data access concerns;
- the lack of standardization across EHRs; and
- the costs associated with the new requirements.

The current eQCM or MIPS CQM approach for National Provider Identifier (NPI) or Tax Identifier Number (TIN) reporting in MIPS:

- Includes only the panel of patients for whom the clinician or group provided direct care;
- Typically requires the clinician or group to extract data from one EHR vendor system or to one approved registry; and
- Does not involve aggregating data across multiple practices, EHRs, or settings.

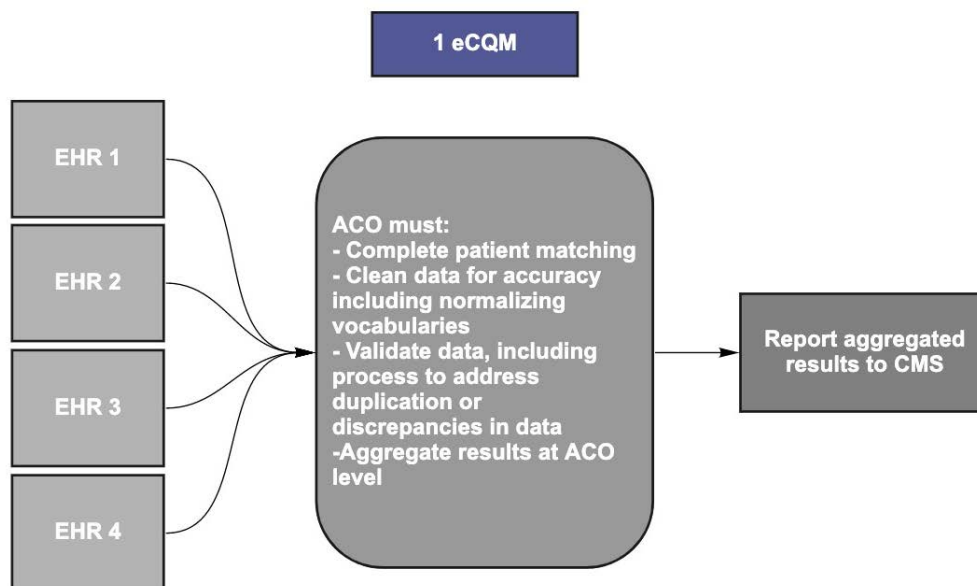
With the changes finalized, ACOs will need to:

- Expand their denominators to include all beneficiaries who meet the measure criteria regardless of payer;
- Aggregate data across multiple TINs and EHR systems; and
- Build the capability to capture, aggregate, and report data across a larger data set, or contract with an entity to perform these tasks.

Impediment #1: Data access concerns

In preparation to meet the new requirements, ACOs are in the process of:

- Reviewing the various TINs and associated EHRs vendor systems;
- Determining the extent to which their current contracts with the clinicians and groups allow them to have access to and permission to report on all payer data; and
- Developing the internal infrastructure or contracting with a company to pull the data from each TIN, complete patient matching, and clean and validate the data for aggregation for the ACO (see figure).

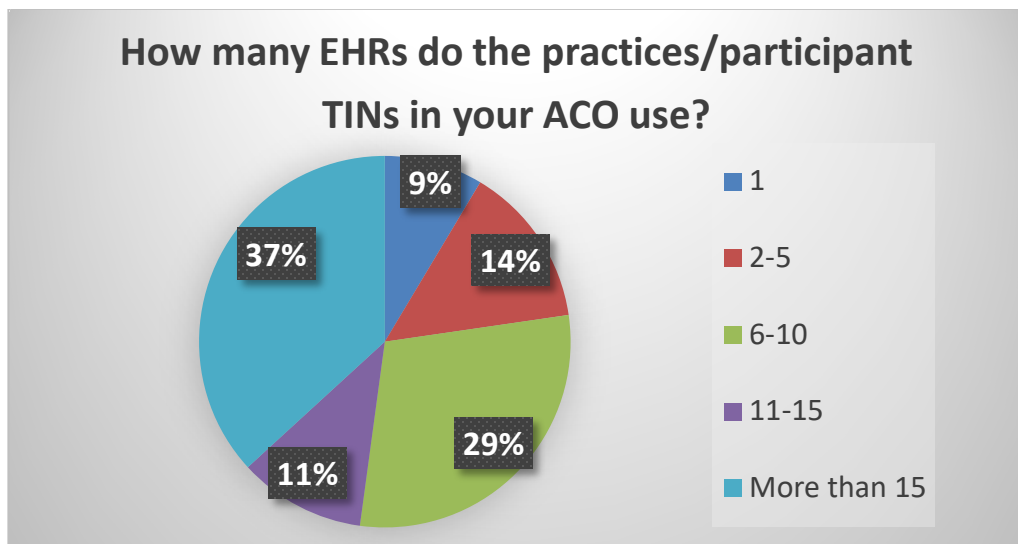


Many ACOs have expressed concerns that they do not currently have the necessary permissions to report on all payer data and data integrity could be impacted. Concerns include:

- An ACO has a contract with the TIN providing care to the ACO’s attributed patients, but they may not have contracts with all of the payers in the TIN’s full patient panel.
- The ACO may not have permission to receive protected health information, and therefore the aggregated data may include duplicates due to their inability to complete patient matching.
- It is not clear how an ACO should handle patients who opt out of data sharing.

Impediment #2: Lack of standardization of EHRs for eCQM reporting

ACOs have a significant number of vendor systems from which the data would be collected. As shown below, when asked how many EHRs the practices/participant TINs in their ACO have, almost 40% of ACOs reported they have more than 15 EHRs, which exponentially complicates things.



It is important to note that even though EHR vendor systems may have achieved 2015 Certified Electronic Health Record Technology (CERHT) and must report the most recent version of an eCQM for MIPS, they are not required to re-test or re-certify to those specifications. In addition, the current testing process does not use an adequate number of test cases to reflect real world implementation. Because of these disconnects between certification, testing, and real-world use, many EHR vendor systems that achieved 2015 CERHT will not be able to seamlessly report eCQMs and easily produce reliable and valid results that accurately represent ACO performance.

Nearly 70% of survey respondents reported their ACO does not have software in place to assist with integrating and extracting quality data from their ACO’s EHRs.

One survey respondent expressed concern over the potential unintended consequences to individual practices:
“There is probably some benefit to lessening manual burden, however the burden on individual practices to set up feeds is greater and more burdensome due to them having less resources than the ACO.”

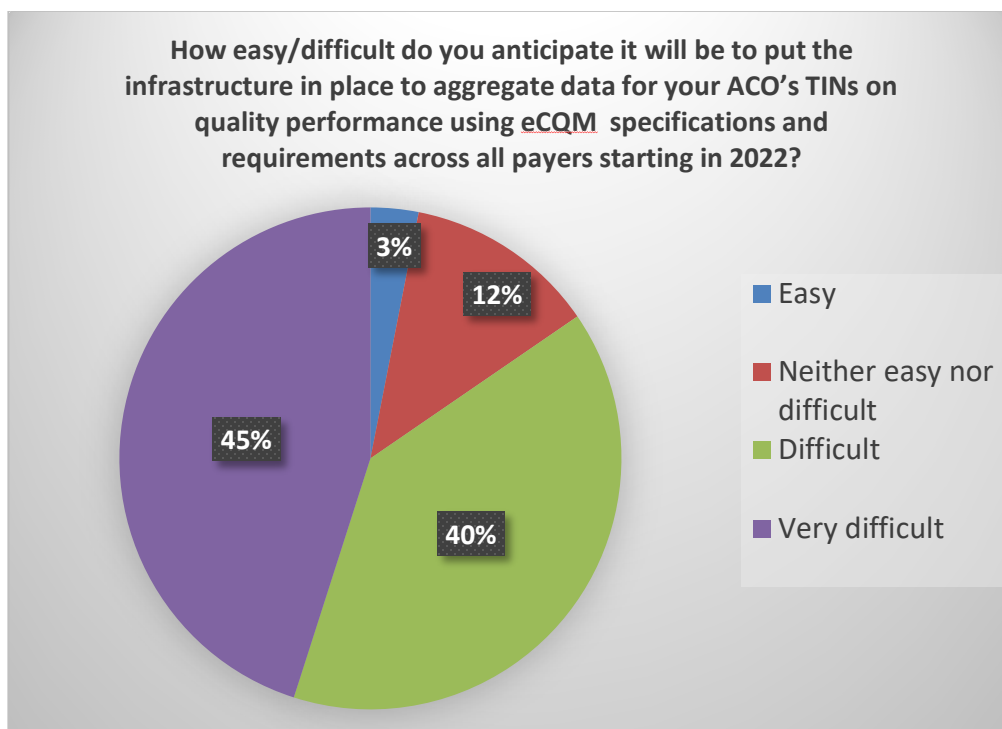
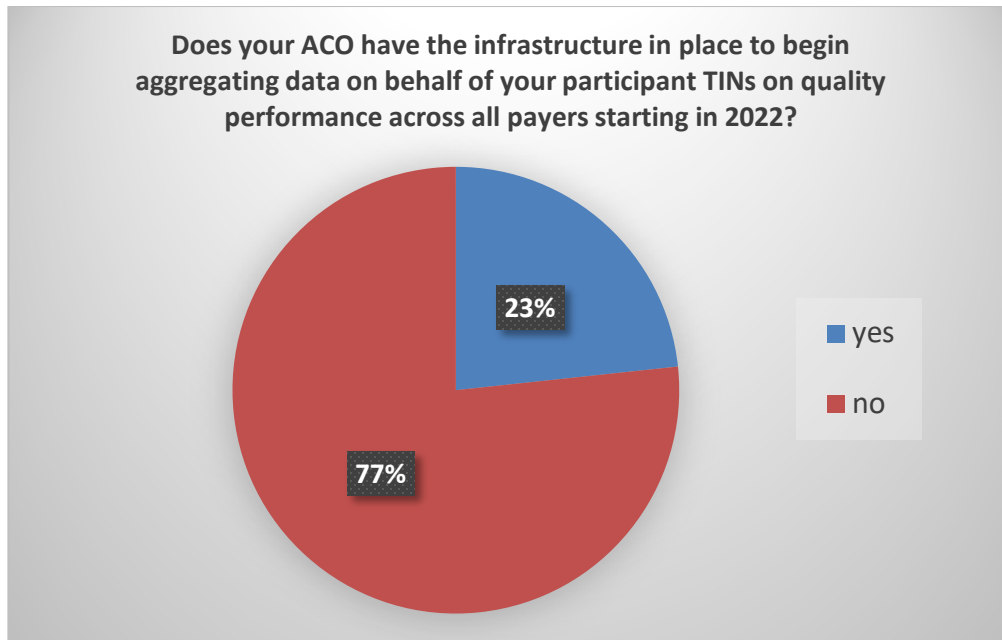
Another respondent was concerned with the “inaccurate information and the potential inability of EHR systems to accurately reflect our measures.” Another stated that: “We have spent a lot of time validating the accuracy of eCQM data across EHRs. Some measures as reported by some systems amounted to up to an 80% difference between what is real and what comes across on the eCQMs. This is not a valid manner of measuring and comparing performance across ACOs.”

Therefore, there is a significant amount of work that must be completed by each ACO to ensure that reliable and valid data are extracted from the various systems. In addition, it is not clear whether some level of data auditing

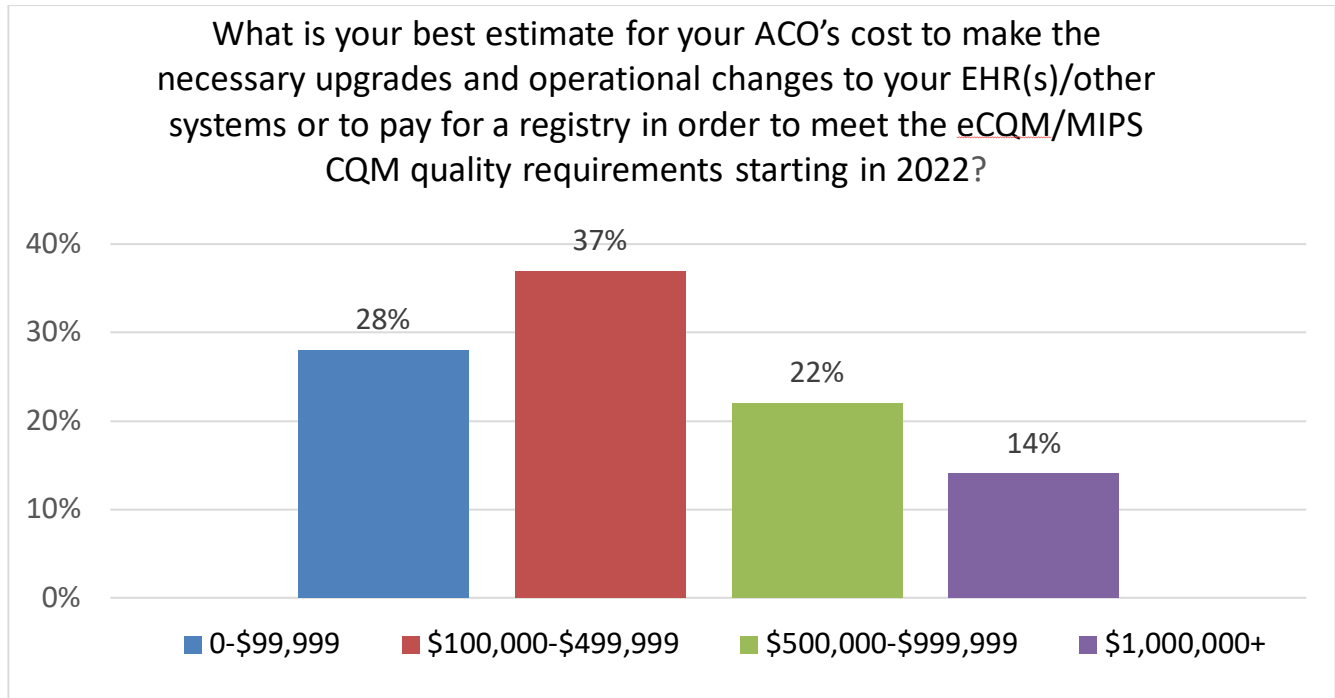
will be required, what criteria should be used to report across all the TINs, or even if ACOs are required to report data for participant TINs only.

Impediment #3: Administrative burdens and costs associated with the new eCQM and MIPS CQM reporting requirements.

Survey respondents shared feedback about the onerous administrative burdens of complying with the shift to eCQMs and MIPS CQMs. As shown below, when asked if their ACO has the infrastructure in place to begin aggregating data on behalf of the ACO’s participant TINs on quality performance across all payers starting in 2022, almost 80% of respondents said “no”. Further, 85% of survey respondents reported that it would be “very difficult” or “difficult” to put that infrastructure in place for 2022. Only 3% reported it would be “easy”.



The administrative burdens are also tied to significant costs, which will strain ACOs during a very challenging time. The resources, staff time and funding used to meet the new requirements would be much better served in other areas, such as improving patient care, responding to the COVID-19 pandemic and implementing new clinical transformations to enhance patient outcomes. Many survey respondents reported they do not know exactly how much it will cost their ACO to comply with the new requirements. However, of those who were able to provide an estimate, many identified the cost would be in the hundreds of thousands of dollars or over a million dollars.



It's important to recognize the timing of these investments. ACOs will need to fund this work upfront, which will be a considerable deterrent for ACOs considering joining the MSSP. Over the course of the program, an average of 35% of ACOs have earned shared savings, illustrating the challenging nature of the program. The uncertainty of earning shared savings means ACOs will have a difficult time funding these quality changes up front, not knowing if they will earn shared savings which are paid roughly nine months after the close of the performance year.

Given the potential impact on operating budgets, ACOs will need additional lead times to price out and build in this work, making it difficult or next to impossible for many ACOs to make this shift in PY2021 or PY2022. Further, given the high cost of this regulatory burden, at a minimum CMS should provide funding to ACOs to meet the requirements, or as recommended above not require the shift to eQMs or MIPS CQMs. One respondent specifically stated that ACOs "need two to three years of lead time to allow the EHR vendor to program the changes, workflow adjustment to capture quality data based on the new feature, and validation the data."

Conclusion: While ACOs recognize there are benefits of reducing manual chart abstraction and reporting, ensuring that data integrity is maintained and the resulting measures are reliable and valid remains of utmost importance. In addition, expansion to the broader population may provide a snapshot of care within a community but is likely not representative of the care provided by the ACO. While NAACOS supports leveraging electronic data sources, the policies finalized by CMS go too far and come with a number of obstacles. Quality is a pillar of the MSSP and moving to reporting of eCQMs and MIPS CQMs across all payers would serve as a distraction and shift resources to reporting activities when they should be used to provide services and improve the quality of care for ACO beneficiaries. We appreciate your consideration of this feedback and welcome continued opportunities to discuss ACO quality with the agency.