ACO Quality Reporting Requirement Changes

ACO quality reporting requirements are changing in 2025. These changes will require ACOs to transition to different systems for reporting quality performance data to the Centers for Medicare and Medicaid Services (CMS). The changes are adding significant burden and costs to ACOs.

How ACOs are assessed on quality now. Since the program's inception, ACOs have reported quality data to CMS using the CMS-administered tool called the Web Interface. This allows ACOs to collect quality data from electronic health record (EHR) data and patient record data in a manner best suited for each practice. Additionally, the tool focuses on a sample of ACO assigned patients, similar to the sampling approach used in Medicare Advantage quality assessments.

Moving to eCQMs/MIPS CQMs. To align Medicare Shared Savings Program (MSSP) quality assessment methods with the Merit-Based Incentive Payment System (MIPS), 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.

Key Changes and Challenges

eCQMs and MIPS CQMs require reporting and assessment on all patients meeting the measure's criteria, regardless of whether that is an ACO patient, or even a Medicare patient.

- 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 also 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. This will harm ACOs with large portions of underserved patients.

eCQM data must be pulled directly from the EHR. This makes aggregating data across systems and varying EHRs very difficult.

- 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 needed to ensure accurate data is being reported to CMS are immense. 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. Further, 16% reported a cost of $500,000 to $999,999.
- Identifying unique patients across systems that do not talk to each other is a challenging, time consuming and costly exercise. 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 Certified EHR Technology (CEHRT) does not solve this problem, as those requirements do not facilitate ACOs combining this quality data across EHRs.

Timeline for Implementation. Because large ACOs on multiple EHRs will have additional costs and human resources needed to solve for these problems, moving to eCQM/MIPS CQM reporting for ACOs by 2025 is not feasible. Applying these MIPS policies, which are focused on and designed for individual physician and group practices, will be difficult for ACOs. CMS should first pilot eCQM and MIPS CQM 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.