September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Brooks-LaSure:

The undersigned organizations strongly urge the Centers for Medicare & Medicaid Services (CMS) to reform its quality and promoting interoperability (PI) requirements for accountable care organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP). Recently finalized changes to these requirements are creating undue burden on ACOs, resulting in unintended consequences for ACOs that treat vulnerable patient populations and are threatening program participation and the transition to alternative payment models (APMs). Failure to address these policies ultimately jeopardizes the Administration's goal of aligning all Medicare beneficiaries in an accountable care relationship by 2030. Below, we offer multiple recommendations for actions that CMS should undertake to address the obstacles that ACOs currently encounter in moving to greater digital quality measurement.

Quality improvement, with quality reporting directly tied to financial incentives, is a cornerstone of ACOs. ACOs consistently provide high quality care and are among the highest quality performers evaluated under the Quality Payment Program. ACOs and the patients they serve desire an efficient, technology-enabled future in which data can be shared bi-directionally to better inform patient care. Digital quality measurement should allow for seamless quality reporting that reduces burden and provides real time performance data that can be used to improve patient care. However, much work remains to achieve these broader goals. What is needed is a more cohesive, thoughtful approach, that does not prematurely push ACOs and participating practices to adopt new data sharing technologies before interoperability standards have caught up, thus risking potential disruptions to patient care.

Current plans to sunset the CMS Web Interface, eliminate Merit-based Incentive Payment System (MIPS) clinical quality measure (CQM) reporting, and require all ACOs to report PI data beginning in calendar year (CY) 2025 will require significant resource investments. However, the ongoing challenges outlined in this CMS infographic remain, a fact that will make successfully operationalizing these policies in the coming year nearly impossible. Much of this investment will be wasted as ACOs will soon need to transition to the HL7 Fast Healthcare Interoperability Resources (FHIR) standard in the coming years.

The unintended consequences of these policies have a direct impact on patients and providers. Forcing ACOs to divert shared savings into temporary technologies detracts resources from

patient care. Additionally, ACOs are feeling forced to remove practices that may need more time to adopt new technologies. These practices tend to be smaller and independent, creating even more barriers for these types of practices to join.

ACOs face an increasingly volatile quality reporting environment

The MSSP quality reporting landscape has grown significantly more complex, burdensome, and volatile in the last few years. In 2021, when CMS signaled the sunsetting of CMS Web Interface reporting, ACOs had to quickly respond and shift to reporting MIPS CQMs and/or electronic clinical quality measures (eCQMs). In 2022, 37 ACOs reported using MIPS CQMs or eCQMs with a lower mean quality score than the 457 ACOs that reported Web Interface. Unfortunately, ACOs continue to encounter significant obstacles, which have required multiple rounds of clarification and discussion with CMS, which are still ongoing.

MIPS CQMs and eCQMs significantly expanded the population on which an ACO's quality is evaluated from a sample of Medicare beneficiaries to all payer data. As a result, ACOs must now aggregate data across all participating practices and frequently across multiple electronic health records (EHRs) and instances of EHRs for both employed and independent practices and clinicians.

Even after addressing these operational challenges, the all-payer requirements may also create unintended consequences. ACO's quality performance is now assessed based on the ACO's entire payer mix, rather than on the quality of care furnished to Medicare beneficiaries affiliated with the ACO. This fact may put ACOs with higher proportions of underserved non-Medicare patients at a disadvantage, as they may now see lower performance on certain metrics for reasons outside the control of the ACO.

Additionally, given the current focus of the measures on primary care services, there is an increased risk of unintended consequences for those ACOs with higher proportions of specialty practices, since these specialists may now be evaluated based on measures that are not appropriate metrics of the care they furnish. Many ACOs report that they are considering dropping specialty practices due to the impact of these unintended consequences. The result of these policies is lost opportunities to engage specialists in value-based care, further hindering CMS goals around advancing value-based specialty care and aligning all beneficiaries with accountable care relationships.

CMS recently recognized the need to assist ACOs in their efforts to aggregate data and complete patient matching and released an open source dedupliFHIR tool. While this is a promising step forward, as with any new technology or tool, its first iteration is not comprehensive and will require refinements. Specifically, testing with real world data needs to be completed to verify its degree of accuracy and ability to handle more complex but necessary tasks such as data normalizing, phonetic matching, and de-duplication/patient matching (i.e., rectifying multiple data elements for one patient), which continues to be a major issue. No other entity that participates in CMS quality programs is required to complete this level of aggregation and

reporting and while a tool such as dedupliFHIR will assist in these efforts, it does not address all the concerns, nor is it prudent to rely on its use without understanding whether it works as intended and produces consistent and accurate results.

In 2023, in response to feedback from the stakeholder community, including many of the organizations on this letter, CMS finalized Medicare CQMs as a viable alternative for ACOs as they transition to MIPS CQMs and eCQMs. While ACOs welcomed the additional option, CMS indicated that Medicare CQMs would only be a temporary solution and that ACOs were expected ultimately to transition to eCQMs or MIPS CQMs. However, CMS has not provided any guidance on how long Medicare CQMs will remain available. As a result, ACOs and EHR vendors are reluctant to invest time and resources into this reporting option, hindering its ability to serve as a viable alternative. Identifying the Medicare CQM patient population requires significant resources and many ACOs and vendors are still trying to operationalize how to do this work, as the first Medicare CQM patient lists were just shared with ACOs in May. Finally, many vendors have elected to not support this option and other EHR vendors will not be ready to do so until late 2025.

After all this, ACOs that did move to MIPS CQMs must now make yet another decision, given CMS's proposal to eliminate MIPS CQMs as reporting option for MSSP effective for 2025. CMS provided no indication through previous rulemaking that this option would no longer be available, and this leaves both ACOs and vendors with little time to accommodate such a significant change. For those who already invested in vendor support to report MIPS CQMs, much of the time and resources invested in this option were wasted. Now, ACOs will have only two months to quickly pivot to another option if this change is finalized Nov. 1. Abruptly removing the MIPS CQM reporting option in the same year CMS plans to retire the Web Interface will harm ACOs and the patients they serve and places vendors in an untenable position as most will not be able to support Medicare CQMs just two months following issuance of the final rule.

Requiring ACOs to report MIPS PI data moves us backwards

As CMS continues to make changes to its expectations on quality reporting for ACOs, the agency recently introduced another set of new requirements for ACOs relevant to Certified EHR Technology (CEHRT). Specifically, based on the final 2024 Medicare Physician Fee Schedule (MPFS) rule, all MSSP participants, regardless of Qualified APM Participant (QP) status or track, must report MIPS PI data starting with the 2025 performance year. Additionally, CMS increased the threshold for Advanced APM CEHRT use, requiring ***all*** eligible clinicians to use CEHRT starting with the 2025 performance year, as opposed to 75 percent of eligible clinicians. While CMS's goal is to have 100 percent CEHRT use, there should be a glidepath to achieving this goal with a more gradual phase in to 100 percent. CMS should also recognize existing MIPS exclusions and exceptions which include valid reasons for excluding certain practices and clinicians from CEHRT requirements.

Despite these significant changes, CMS did not address the new requirements in the recently released proposed 2025 MPFS rule. As discussed in a previous sign-on letter, these additional reporting burdens do not contribute to better patient care and will serve as a disincentive for participation in Advanced APMs. As noted earlier, these changes are poorly timed as ACOs will soon need to transition to FHIR standards. Moreover, under the new Insights Condition and Maintenance of Certification data finalized in the Health Data, Technology, and Interoperability (HTI-1) Final Rule, certified health IT developers will soon be required to report on use of their products across four areas related to interoperability, which will reflect real-world physician use of CEHRT in actual clinical settings, rendering this massive data reporting exercise largely obsolete.

Lastly, CMS has not provided evidence explaining how the inclusion of PI and increased CEHRT requirements will increase interoperability among health IT products used by ACOs. We expect the provider information blocking penalties to be a powerful incentive without the need to burden physicians with duplicative and burdensome PI reporting requirements. Moreover, information blocking policies reach beyond CEHRT so they would be more effective at advancing information exchange across a range of emerging technologies than the proposed policies, which are limited strictly to CEHRT.

Recommendations

We strongly support CMS's goal of moving toward digital measurement and appreciate efforts to address ongoing concerns. However, significant challenges remain. To facilitate a successful move to digital quality measures (dQMs), CMS must address the obstacles ACOs are currently encountering. We therefore urge CMS to undertake the following actions:

1. **Delay sunsetting the Web Interface and MIPS CQM reporting methods in 2025 for three additional years to align with the timeline required in the CMS Interoperability and Prior Authorization Final Rule.**

2. **Assure ACOs that the Medicare CQM option will be available for the foreseeable future until dQM reporting is successful.**

3. **Repeal new PI requirements for MSSP ACOs and the increase in CEHRT requirements for Advanced APMs taking effect in 2025. Instead, institute a "yes/no" attestation to demonstrate CEHRT adoption and compliance with information blocking requirements, and leverage ONC data already set to be collected directly from certified health IT developers under the new Insights Condition and Maintenance of Certification finalized in the HTI-1 Final Rule.**

Implementing our proposed recommendations will enable ACOs to continue to prioritize improving the quality of care provided to patients and enable a smooth transition to digital quality measurement. It will also place CMS in a better position to realize its goals of having 100 percent of Medicare fee-for-service beneficiaries in an accountable care relationship by 2030.

The undersigned organizations look forward to continuing to partner with CMS to pave the way to a digital quality measurement and health information technology future that improves patient care and helps more practices transition to value-based care.

Sincerely,

American Medical Association
Americas Physician Groups
Association of American Medical Colleges
Health Care Transformation Task Force
Medical Group Management Association
National Association of ACOs
National Rural Health Association
Premier Inc.

Health Systems, Hospitals, Physician Practices, Health Clinics and ACOs

ACO Collaborative, LLC
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Community Care of Brooklyn IPA
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Crossroads Family Medicine
Cumberland Center for Healthcare Innovation
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Eventus WholeHealth
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Family Practice Associates of Lexington
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Georgetown Internal Medicine
HarmonyCares Medical Group
Health First Physicians ACO
Henry Ford Physicians Accountable Care Organization, Mosaic ACO
IHCI ACO LLC
Illinois Rural Community Care Organization
Imperium Health
Innovation Care Partners
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Integra Community Care Network
Integra Community Care Organization
Lancaster General Health Community Care Collaborative
LTC ACO
Lumeris
MaineHealth ACO
Mass General Brigham
McLaren High Performance Network LLC
MercyOne
Methodist Alliance for Patients and Physicians
Methodist Patient Centered ACO
Minnesota Medical Association
Mission Health Partners
Mt. Sterling Clinic, PLLC
MultiCare Connected Care
MultiCare Health Partners
Nebraska Medicine
Northfield Hospital + Clinics
NW Momentum Health Partners ACO
Ochsner Health

OneHealth Nebraska ACO
Primary PartnerCare ACO Independent Practice Association, Inc
PSW ACO
Responsive Care Solutions
Richmond Primary Care PLLC
Riverside Health Source Inc.
Rochester Regional Health ACO, Inc.
Saint Francis Accountable Health Alliance
Select Physicians Associates LLC
Silver State ACO
Southeastern Health Partners
Statera Health, LLC
Staton Southern Medical
Summit Health
TC2
Trinity Health Integrated Care, LLC
Trinity Health of New England
Trinsic Clinically Integrated Network
Tulane University Medical Group
UNC Senior Alliance/UNC Health Alliance
University Hospitals Health System
Wellstar Clinical Partners Medicare ACO
Wilems Resource Group
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