Congress of the United States

Washington, DC 20515

October 25, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

We write to urge the Centers for Medicare and Medicaid Services (CMS) to reconsider how Accountable Care Organizations (ACOs) report quality measures. The finalized details of the transition to digital Quality Measures (dQMs) will create significant challenges in our shared goal of helping more providers shift to value-based care, especially for small and independent practices.

ACOs are historically among the strongest provider groups that report quality data and have a proven track record of improving health outcomes for Medicare beneficiaries while reducing costs. CMS's planned transition to dQMs in January will retire older, burdensome methods of reporting and instead require aggregated data from electronic health record (EHR) platforms, known as dQMs. This will reduce countless hours of administrative downtime by eliminating copying and pasting of patient data. The new streamlined method of quality reporting is estimated to yield significant savings for independent practices and save clinicians' time, so they can devote more resources to providing better care.

While we support CMS's transition to dQMs, we are concerned about CMS's commitment to ensuring small and independent practices' ability to participate in programs that require quality reporting. Cost savings may arise in the long run from dQM implementation, but the initial investment required to comply with new requirements places a daunting financial burden on participating ACO providers. Nearly 40 percent of ACOs estimate complying with dQM requirements to cost between $100,000 to $500,000, and 14 percent of ACOs estimate compliance costs greater than $1,000,000 dollars.[1] ACOs have a proven track record of improving health outcomes for Medicare beneficiaries while reducing costs, yet the high cost of dQM compliance could deter ACO provider participation in both the near and long term, especially for small practices.

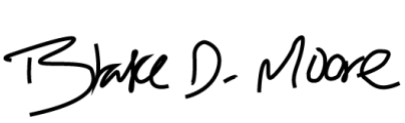
In light of these concerns, we urge CMS to provide more flexibility to small and independent practices using existing EHRs in the interim while pursuing a more modern and integrated quality reporting system in the future. While these EHRs may not meet the newer reporting requirement standards, they still create a pathway for small and independent practices to

[1] National Association of ACOs (NAACOS), "Feedback on Moving ACO Quality Reporting to eCQMs and MIPS CQMs," https://www.naacos.com/wp-content/uploads/2024/01/NAACOS-QualityhandoutCCSQmeeting03222021.pdf

functionally exchange quality data crucial to participating in value-based payment arrangements. Conversely, the finalized details on the transition to dQMs – which cater primarily to ACOs and practices with newer EHRs – lose the key goal of reducing administrative burden by leaving smaller practices with less sophisticated EHRs behind. This feature of dQM implementation is particularly problematic since ACOs typically represent providers using 15 or more different EHR platforms with varying levels of sophistication.[2] Without flexibility from CMS, the only option is to continue more cut-and-paste solutions and workarounds that are costly and time-consuming – undercutting the entire purpose of the transition to dQMs. We should not lose sight of the promise of investing in digital quality measures reporting, but this transition must be tailored to improve care without harming providers participating in value-based care programs.

We look forward to working with you on efforts to streamline Medicare's quality programs in ways that improve patient outcomes and reduce burdens on providers and the health care system.

Sincerely,



Blake D. Moore
Member of Congress

Darin LaHood
Member of Congress

[2] *Id.*