Reporting to Scoring: MSSP Quality Overview

Introduction — MSSP quality overview

In the 2021 Medicare Physician Fee Schedule (MPFS) Rule, CMS finalized a major overhaul of the quality reporting and assessment structure for Medicare Shared Savings Program (MSSP) ACOs, transitioning to the APM Performance Pathway (APP). CMS created the APP to better align quality measurement approaches for MSSP with the Quality Payment Program (QPP) Merit-Based Incentive Payment System (MIPS) quality reporting and assessment approaches. Part of this transition includes CMS's plans to retire the Web Interface (WI) reporting option and require all ACOs to report electronic clinical quality measures (eCQMs) or MIPS clinical quality measures (CQMs) beginning in Performance Year (PY) 2025.

ACOs are evaluated on a number of quality measures, which allows CMS to assess the quality of care being provided to patients served by ACOs. These quality evaluations also determine whether an ACO is eligible to keep a portion of any financial savings it may generate, which is shared with CMS. Conversely, if shared losses are owed to CMS, the quality score determines the portion of losses the ACO must pay to CMS. MSSP ACOs are not required to report additional quality measures for MIPS beyond those included in the APP set that are scored for both MSSP and MIPS quality assessments (when applicable). ACOs in the first year of their contracts are provided with full credit so long as the ACO completely and accurately reports all quality measures to CMS (pay-for-reporting). Each subsequent year, the ACO will be assessed on quality measure performance for each prescribed measure in the measure set (pay-for-performance).

Quality Reporting Overview

The APP includes three reporting options for ACOs:

- Web Interface
- eCQMs
- MIPS CQMs

There are notable differences among these reporting options. The Web Interface tool provides a sample of assigned ACO patients on which the ACO reports quality measure data to CMS. The process requires manual abstraction of medical charts and allows for a straightforward and accurate way of reporting patient quality information to CMS. Reporting eCQMs across an ACO involves significant data aggregation efforts, and it does not allow for any manipulation of the data pulled from discrete fields in the Electronic Health Record (EHR). MIPS CQMs do allow for supplementation of the data found in discrete fields of the EHR, however may come with additional costs (registry support) and data aggregation issues are also present with this reporting option. The eCQM and MIPS CQM reporting options also require reporting on and evaluation of all patients meeting the measure criteria, regardless of assignment status or payer. This expands the denominator dramatically and can make data aggregation issues even more challenging. Given these differences, each reporting type has a different benchmark.

ACOs can choose to report via one or multiple reporting methods. If the ACO reports via more than one reporting method, CMS will award the highest score to the ACO. Note that measure specifications will vary based on reporting type selected. Always be sure to refer to the final set of measure specifications for the particular reporting method you have selected.

Comparing Web Interface, eCQM, and MIPS CQM Reporting Characteristics

	Web Interface	**eCQM**	**MIPS CQM**
Patient Population	Medicare	All payer	All payer
Eligible population (meet the denominator criteria)	Beneficiaries assigned to the ACO	All patients	All patients
Required sample size	Minimum of 248 consecutive Medicare beneficiaries	Minimum of 70% of the eligible population	Minimum of 70% of the eligible population
Data sources	Manual chart abstraction	Electronic health records extraction – no abstraction/manual manipulation or supplementation permitted	Flat files, registry, EHR + abstraction permitted

Web Interface Reporting

ACOs have long used the Web Interface reporting tool to report quality measure data to CMS for purposes of MSSP evaluations. The tool requires reporting on a minimum of 248 consecutive Medicare ACO assigned patients. The reporting process requires manual abstraction of medical charts, which takes place during the reporting period occurring January to March of the year following the performance year. Web Interface reporting is limited to a sample of assigned ACO patients included in the Web Interface tool. CMS will retire the Web Interface reporting option in 2025 (meaning the last year ACOs can use the Web Interface is for 2024 quality data performance, which is reported in early 2025).

When reporting via Web Interface you will report/be scored on 10 total measures:

- 7 clinical quality measures
- 2 administrative claims measures
- The CAHPS for MIPS survey summary measure

Annually, CMS may determine there is no way to calculate a measure benchmark for a particular measure or a need to suppress the measure for other reasons. It is important to check rulemaking annually (through the Medicare Physician Fee Schedule Rule) for any updates to measure specifications and to determine how many measures will be scored for a particular year. If CMS determines there is an issue with a measure, then the measure is suppressed, rather than giving an ACO full credit for the measure automatically (pay-for-reporting). This is described further in the scoring section of this resource. Note that measure specifications will vary based on reporting type selected. Always be sure to refer to the final set of measure specifications for the particular reporting method you have selected.

eCQM Reporting

CMS defines eCQMs as a clinical quality measure that is expressed and formatted to use data from EHRs and/or health information technology to measure health care quality specifically using data captured in structured form in the EHR. There is no manual abstraction or supplemental data added when reporting quality data to CMS. When reporting via eCQMs, ACOs must aggregate data across all participant Tax Identification Numbers (TINs) and submit one aggregate file to CMS. Additionally, eCQM reporting requires the ACO to report on all patients meeting the measure criteria, regardless of assignment status and payer status. This expands the denominator dramatically as compared to Web Interface reporting, which is limited to a sample of assigned ACO patients.

When reporting via eCQMs you will report/be scored on six total measures:

- 3 electronic clinical quality measures
- 2 administrative claims measures
- The CAHPS for MIPS survey summary measure

Annually, CMS may determine there is no way to calculate a measure benchmark for a particular measure or a need to suppress the measure for other reasons. It is important to check rulemaking annually (through the Medicare Physician Fee Schedule Rule) for any updates to measure specifications and to determine how many measures will be scored for a particular year. If CMS determines there is an issue with a measure, then the measure is suppressed, rather than giving an ACO full credit for the measure automatically (pay-for-reporting). This is described further in the scoring section of this resource. Note that measure specifications will vary based on reporting type selected. Always be sure to refer to the final set of measure specifications for the particular reporting method you have selected.

Quality measure specifications for eCQMs/MIPS CQMs are presented differently than Web Interface measure specifications. To assist ACOs, NAACOS has developed the Guide to Accessing eCQM Specifications for ACOs, available for NAACOS members.

Data Aggregation

ACOs will be expected to aggregate and do patient matching and report one aggregate quality submission to CMS. In the final 2022 MPFS Rule, CMS provides additional detail regarding aggregation expectations. Specifically, CMS notes the following: *We note that the ACO would utilize the QRDA I format, which specifies patient level collection of data from each of the ACO's participant TINs. The ACO would then aggregate these data across the ACO and submit them to CMS in the QRDA III format. Collecting and aggregating these data in the QRDA I format allows for de-duplication given the granularity of the data (p. 65261).*

While the Quality Reporting Document Architecture (QRDA) I format provides additional patient-level detail such as name, sex, date of birth, and other details to assist in de-duplication, ACOs will still need to match patients and data across National Provider Identifiers (NPIs) and TINs on a measure-by-measure basis. ACOs could also contract with a third-party intermediary, such as a registry or Health Information Exchange, to submit data and should ensure that they select a vendor with sufficient experience in data aggregation and patient. This complex data aggregation process could take significant resources from the ACO both in time and effort as well as monetary investments, particularly if an ACO must rely on a vendor to support the data aggregation and de-duplication of patients across the ACO.

Additionally, in guidance published in December 2022, CMS provided additional detail regarding patient matching expectations. On page 10, CMS notes:
ACOs that have experience reporting eCQMs and MIPS CQMs have described success in achieving patient matching rates of 90 percent or higher using common variables such as first name, last name, date of birth, phone number, and email. Under current CEHRT requirements, EHRs are required to support each of these data elements for certification. ACOs have also indicated the benefits of using solutions such as an Enterprise Master patient Index (EMPI). While variable selection and matching criteria may vary across organizations, ACOs should identify an appropriate combination of variables to achieve consistent and replicable patient matching that provides the most complete and accurate data to meet the measure specification and valid and reliable measure performance. CMS may request the ACO's technical documentation and internal organizational policies that document the ACO's approach to patient matching, parsing and data cleansing to ensure that the ACO's reporting is true, accurate and complete at the ACO level.

Data Completeness
Reporting via eCQM requires at least 70 percent data completeness is met. Data completeness refers to the volume of performance data reported for the measure's eligible population. When reporting a quality measure, you must identify the entire eligible population (or denominator) as outlined in the measure's specification. To meet data completeness criteria for eCQM/MIPS CQM reporting, you must report performance data (performance met or not met, or denominator exceptions) for at least 70 percent of the eligible population (denominator). As a reminder, sections 414.1390(b) and 414.1400(a)(5) provide that all MIPS data submitted by or on behalf of a MIPS eligible clinician, group, virtual group, APM Entity, opt-in participant, and voluntary participant must be certified as true, accurate and complete. Incomplete reporting of a measure's eligible population or otherwise misrepresenting a clinician or group's performance (e.g., only submitting favorable performance data) would not be considered true, accurate, or complete.

Finally, CMS clarified in a webinar for ACOs in December 2022, as well as via guidance published in December 2022, that all of an ACO's participant TINs must be on Certified EHR Technology (CEHRT) in order to use the eCQM reporting method.

CMS published a resource for ACOs on reporting eCQMs and MIPS CQMs in December 2022 with additional information on these reporting types, reporting scenarios, and frequently asked questions. For more detailed and technical information about reporting eCQMs as well as NAACOS advocacy on this issue, please refer to our website.

MIPS CQM Reporting
ACOs can also elect to report via MIPS CQMs. MIPS CQM reporting is often supported by a registry or another vendor at a cost to the ACO. In addition to EHR structured data, flat files, registry and EHR data supplemented by abstraction can be used in reporting MIPS CQMs. Similar to eCQM reporting, the data must be aggregated across all participant TINs in the ACO, which comes with patient matching/de-duplication challenges. Like eCQM reporting, MIPS CQM reporting also has a 70 percent data completeness requirement and will require the ACO to report on all patients meeting the measure criteria, regardless of assignment status and payer status.

When reporting via MIPS CQMs you will report/be scored on six total measures:
- 3 MIPS clinical quality measures
- 2 administrative claims measures
- The CAHPS for MIPS survey summary measure

Annually, CMS may determine there is no way to calculate a measure benchmark for a particular measure or a need to suppress the measure for other reasons. It is important to check rulemaking annually (through the Medicare Physician Fee Schedule Rule) for any updates to measure specifications and to determine how many measures will be scored for a particular year. If CMS determines there is an issue with a measure, the measure is suppressed, rather than giving an ACO full credit for the measure automatically (pay-for-reporting). This is described further in the scoring section of this resource. Note that measure specifications will vary based on reporting type selected. Always be sure to refer to the final set of measure specifications for the particular reporting method you have selected. CMS published a resource for ACOs on reporting eCQMs and MIPS CQMs in December 2022 with additional information on these reporting types, reporting scenarios and frequently asked questions.

Quality Benchmarks

Benchmarks for each individual quality measure and each reporting type are established annually. These individual quality measure benchmarks are different from the quality performance standard threshold that is used to determine whether ACOs can share in maximum savings (more information on this calculation is available in the scoring section of this resource). Individual measure benchmarks can be accessed via the CMS website (search 'quality benchmarks' in the Quality Payment Program Resource Library) and are updated annually.

APP Measure Set for 2023

eCQM/MIPS CQM	Web Interface
Diabetes: HbA1c Poor Control (>9%)	Diabetes: HbA1c Poor Control (>9%)
Controlling High Blood Pressure	Controlling High Blood Pressure
Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Preventive Care and Screening: Screening for Depression and Follow-Up Plan
CAHPS for MIPS Survey	Screening for Future Fall Risk
Administrative Claims Measures: 1. Hospital wide 30-day, all cause unplanned readmission rate 2. Hospital admission rates for patients with multiple chronic conditions	Influenza Immunization
	Tobacco Use: Screening and Cessation Intervention
	Colorectal Cancer Screening
	Breast Cancer Screening
	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
	Depression Remission at 12 Months
	CAHPS for MIPS Survey
	Administrative Claims Measures: 1. Hospital wide 30-day, all cause unplanned readmission rate 2. Hospital admission rates for patients with multiple chronic conditions

*Measure specifications vary based on reporting method selected; shading indicates outcome/intermediate outcome measure

Quality Scoring Overview

In the MSSP, quality scores dictate what an ACO's final sharing rate will be and what losses will be owed (if applicable). Beginning PY 2022 and subsequent years, ACOs who meet or exceed the quality performance standard will receive the maximum shared savings rate available in their track/model. Those

who meet a lower standard can receive a portion of shared savings, determined based on their final quality score.

Quality Performance Standard
ACOs must meet or exceed the quality performance standard to be eligible to share in savings they may generate. For 2022 and 2023 the quality performance standard is set at the 30th percentile of MIPS quality scores. For 2024 and subsequent years, the quality performance standard is set at the 40th percentile of MIPS quality scores. Because the quality performance standard is calculated based on the final distribution of MIPS quality scores, the score is not known until after the close of the performance year. ACOs who meet or exceed this quality performance standard will share in savings at the maximum sharing rate.

For ACOs who do not meet the higher quality performance standard to share in savings at the maximum sharing rate but can meet or exceed the 10th percentile on an individual quality measure benchmark for at least one of the outcome measures listed in the measure set, the ACO's final sharing rate would be scaled by multiplying the maximum sharing rate for the ACO's track/level by the ACO's final quality score (including any bonus points). The individual measure performance benchmarks are known in advance of the start of the performance period, while the quality performance standard threshold is not known until after the performance period closes. Tying the lower threshold to individual measure performance benchmarks brings some needed certainty to ACOs trying to forecast performance.

Hypothetical Example
An ACO participating in Basic Track Level B met the minimum savings rate and qualifies for shared savings with a final quality score of 45 points. This score is less than the 30th percentile of MIPS quality performance category scores of 67 points. Therefore, the ACO will not receive the maximum shared savings rate. The ACO did achieve a quality performance score higher than the 10th percentile for an individual measure benchmark on one of the outcome measures, therefore, the ACO is eligible to share in a portion of the savings.

The shared savings rate in this example would be 40 percent (maximum sharing rate for Basic Track Level B) x 45 percent (final quality score) = final sharing rate of 18 percent.

Historic Scores for Quality Performance Standard
Because the quality performance standard is calculated based on the final distribution of MIPS quality scores, the score is not known until after the close of the performance year. NAACOS has called on CMS to develop an approach that provides ACOs with more transparency, specifically asking CMS to publish all MIPS quality performance category scores in the MIPS Public Use Files. Currently, CMS only publishes historic scores calculated by CMS. Please note that PY 2021 was the first year the quality performance standard was applied to ACOs.

Historic Quality Performance Standard Scores 2018–2021

Quality Performance Category Scores	30th percentile	40th percentile
2018	59.3	70.8
2019	58.0	70.82
2020	63.90	75.59
2021	61.7	77.8

Shared Losses and Quality Scores — Enhanced Track Participants

CMS finalized a policy to alter the shared loss rate calculation for Enhanced Track ACOs that do not meet the quality performance standard threshold. Beginning in PY 2023, an ACO that meets the existing quality performance standard or that meets the new alternative quality standard would have shared losses scaled to one minus the product of the maximum sharing rate for the Enhanced Track (75 percent) and the ACO's quality performance score (including any health equity bonus points). The scaled shared loss rate would be subject to a minimum of 40 percent and a maximum of 75 percent. An ACO that fails to achieve the alternative quality performance score (10th percentile or higher on one outcome measure in the APP set) continues to automatically share in losses at the maximum shared loss rate of 75 percent.

Incentives for Reporting eCQM/MIPS CQM

CMS established an incentive for ACOs reporting eCQMs or MIPS CQMs in 2022, 2023, or 2024. To be eligible to achieve maximum shared savings, ACOs reporting eCQMs/MIPS CQMs must achieve (1) a quality performance score of the 10th percentile or higher for at least one of the four outcome measures in the measure set and (2) a quality performance score of the 30th percentile or higher for one of the remaining five measures in the measure set. CMS looks at individual measure benchmarks to determine percentile scores for this calculation; performance benchmarks vary based on the reporting method used.

Calculating an ACO's Final Quality Score

CMS will determine an ACO's achievement points earned for each individual quality measure in the measure set by comparing the ACO's performance on the measure to the established benchmark for the measure. Individual measure benchmarks vary based on the reporting method being used and are established in advance of the performance year. ACOs in the first year of their contracts are provided with full credit so long as the ACO completely and accurately reports all quality measures to CMS (pay-for-reporting). Each subsequent year, the ACO will be assessed on quality measure performance for each prescribed measure in the measure set (pay-for-performance).

Benchmarks by Decile for #236: Controlling High Blood Pressure

Measure Title	Measure ID	Collection Type	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Controlling High Blood Pressure	236	MIPS CQM	20.00 - 29.99	30.00 - 39.99	40.00 - 49.99	50.00 - 59.99	60.00 - 69.99	70.00 - 79.99	80.00 - 89.99	>= 90.00
Controlling High Blood Pressure	236	Medicare Part B Claims	20.00 - 29.99	30.00 - 39.99	40.00 - 49.99	50.00 - 59.99	60.00 - 69.99	70.00 - 79.99	80.00 - 89.99	>= 90.00
Controlling High Blood Pressure	236	eCQM	51.76 - 56.80	56.81 - 60.66	60.67 - 64.10	64.11 - 67.51	67.52 - 71.10	71.11 - 75.53	75.54 - 81.42	>= 81.43

Formula used to calculate achievement points for an ACO with a performance score of 72.15%

Apply the following formula based on the measure performance and decile range:

$$\text{Achievement points} = X + \frac{(q - a)}{(b - a)}$$

$$\text{Achievement points} = 7 + \frac{(72.15 - 71.11)}{(75.54 - 71.11)} = 0.2347$$

Achievement points = 7.2

X = decile #
q = performance rate
a = bottom of decile range
b = bottom of next decile range

Note: Partial achievement points are rounded to the tenths digit for partial points between 0.01 to 0.89. Partial achievement points above 0.9 are truncated to 0.9

CMS then sums the total achievement points for all measures to create a total quality score. Finally, CMS adds any bonus points (if applicable) including a new quality equity bonus available beginning in PY 2023 and subsequent years, to calculate a final quality score for the ACO. This final quality score is the score that must meet or exceed the quality performance standard in order to be eligible to share in savings at the maximum shared savings rate available.

Quality Equity Bonus Points

Beginning in PY 2023, CMS finalizes a policy to establish a health equity adjustment that would award bonus points to the quality performance score for ACOs delivering high quality care to underserved populations. The bonus points are only available to ACOs reporting eCQMs or MIPS CQMs. Specifically, up to 10 health equity bonus points will be added to the total quality score for qualifying ACOs with the total quality score not to exceed 100 points. The number of bonus points earned would be based on the ACO's performance on quality measures and the population served by the ACO. The bonus points will be applied only in certain MSSP calculations, such as the quality performance standard determinations, calculations of shared savings/losses, and extreme and uncontrollable circumstances policy calculations.

To determine an ACO's health equity adjustment bonus points, CMS will conduct the following steps:

1. Calculate the performance measure scaler. The scaler is calculated for each measure, thus an ACO may fall into a difference performance group for each measure. For the CAHPS measure and claims-based measures, ACOs will be compared to all ACOs performance on those measures. For all other measures performance is evaluated on ACOs reporting eCQMs/MIPS CQMs. The ACO's measure performance scaler is the sum of the points for each of the six measures; the maximum total scaler is 24.
    - Top third performing ACOs awarded scaler of 4
    - The middle third performing ACOs awarded scaler of 2
    - The bottom third performing ACOs awarded scaler of zero; ineligible to receive health equity bonus points for this measure
2. Calculate the ACO's underserved multiplier for each ACO. CMS will use the higher value of either:
    - The proportion of an ACO's assigned beneficiary population residing in a census block group with ADI national percentile rank of 85 or higher
    - The proportion of an ACO's assigned beneficiary population that are dually eligible for Medicare and Medicaid
    - The proportion of assigned beneficiaries enrolled in the Part D Low Income Subsidy (LIS)
    - If an ACO has less than 20 percent of its population in either category, the ACO is ineligible for the health equity bonus points.
3. Calculate the ACO's health equity bonus points. The ACOs' performance measure scaler (up to 24 points) is multiplied by the ACO's underserved multiplier. The bonus points are capped at 10.
    - For example, an ACO that is a high performer across all six measures (performance scaler of 24) with half of the population served being dual-eligible beneficiaries (underserved multiplier of 0.5) would have health equity bonus points of 12. Therefore, the bonus points would be capped at 10.

The health equity quality bonus points (health equity adjustment) will be available for PY 2023 and subsequent performance years for ACOs reporting eCQMs/MIPS CQMs. CMS will incorporate the health equity adjustment into quality performance reports for MSSP ACOs. CMS will show the calculation of the health equity adjustment, including dual eligibility, LIS and ADI data for all ACOs that report on eCQM/MIPS CQM measures even if the adjustment would not affect the determination of shared

savings/losses. CMS plans to share information on these calculations in ACO reconciliation report packages. In addition, CMS also plans to share quarterly and annually, certain beneficiary-identifiable data on dual eligibility, LIS and ADI national percentile rank to enable greater transparency into the calculation of the health equity adjustment.

Suppressing Measures

Annually, CMS may determine there is no way to calculate a measure benchmark for a particular measure or need to suppress the measure for other reasons. It is important to check rulemaking annually (through the Medicare Physician Fee Schedule Rule) for any updates to measure specifications and to determine how many measures will be scored for a particular year. If CMS determines there is an issue with a measure, the measure is suppressed, meaning it is removed from the measure set when scoring measures to calculate an ACO's final quality score. This is in contrast from the previous policy, where ACOs were given full credit for the measure automatically (pay-for-reporting) when there was an issue with the measure.

Sharing Feedback with ACOs on Performance

CMS provides a preview of the quality score via the QPP portal. ACOs get preliminary access to results with the QPP quality submission. Final quality scores are shared via the financial reconciliation package, which is accessed through the ACO Management System (ACO-MS) data hub.

MIPS Errors and ACO Financial Determinations

MSSP shared savings and loss calculations are tied to whether an ACO meets the established quality performance standard, which is calculated based on the distribution of MIPS quality performance category scores. CMS has sole discretion to make corrections to a prior performance year's MSSP ACO financial determinations as a result of corrections made to MIPS quality performance category scores. Typically, CMS provides MSSP financial reconciliation reports in August of the year following the performance year, with payments to ACOs initiated in September. The timeline for conducting MIPS targeted review may extend past the date CMS issues financial reconciliation reports. Accordingly, CMS may learn of MIPS quality performance calculation errors after MSSP initial financial performance determinations are issued. CMS notes where possible, it would seek to adjust the shared savings payment or shared loss recoupment for the ACO as part of the reconciliation for a subsequent performance year. This approach would not alter the current requirement that ACOs repay shared losses within 90 days after notification of the initial determination of shared losses. NAACOS will closely monitor this process and the impact of MIPS scoring errors on ACO payment determinations and advocate for minimal disruption to ACOs.

Extreme and Uncontrollable Circumstances Policy for ACO Quality

Under the Extreme and Uncontrollable Circumstances policy, an affected ACO that fails to report quality data or reports but fails to meet data completeness or case minimum requirements will have its quality score set to the quality performance standard (i.e., achieves the maximum shared savings rate). An ACO affected by an extreme and uncontrollable circumstance that meets the alternative (lower) quality performance standard would continue to qualify for the maximum sharing rate for its track/level rather than receiving a sharing rate scaled based on the ACO's quality performance.