# 2024 Quality Reporting Requirements: MSSP ACOs

Medicare Shared Savings Program (MSSP) ACOs are required to report quality measure data to the Centers for Medicare and Medicaid Services (CMS) to assess the quality of care provided to patients served by ACOs. These quality evaluations also determine whether an ACO is eligible to receive a portion of financial savings, if generated by the ACO and what losses they must repay to CMS, if applicable. If an ACO is also subject to the Merit-Based Incentive Payment System (MIPS), quality data reported for purposes of the MSSP will also be used to determine the ACO's quality score for MIPS.

MSSP ACOs report quality through the APM Performance Pathway (APP). CMS created the APP to align MSSP quality requirements with MIPS. 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).

This resource reviews reporting options for MSSP ACOs for 2024:

- Web Interface
- eCQMs
- MIPS CQMs
- Medicare CQMs

## Reporting Options

In 2024, ACOs can report quality measures using the CMS Web Interface, electronic clinical quality measures (eCQMs), MIPS clinical quality measures (MIPS CQMs), or Medicare clinical quality measures (Medicare CQMs). Starting in Performance Year (PY) 2025, the Web Interface will no longer be an available reporting option for ACOs (these data are reported in early 2026).

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 or additional vendor 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. Medicare CQMs are a new reporting option for PY 2024 added in response to

NAACOS' concerns with the all-payer requirements. Medicare CQMs require reporting of MIPS CQM measures but limited to Medicare patients meeting ACO assignment criteria.

ACOs can choose to report via one or multiple reporting methods. If the ACO reports using 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, MIPS CQM and Medicare CQM Reporting Characteristics**

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

*see below for more detail on the eligible patient population for Medicare CQMs

***Web Interface***

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). 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 an eCQM 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). 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). 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.

***Medicare CQM Reporting***

CMS added a new reporting option for MSSP ACOs available in PY 2024, Medicare CQMs. Medicare CQMs were added as an option in response to NAACOS advocacy and concerns raised regarding the all payer approach the eCQM and MIPS CQM reporting options use. Medicare CQMs allow an ACO to report MIPS CQM measures on a more limited patient population. If reporting Medicare CQMs, the ACO will report MIPS CQM measures on Medicare fee-for-service beneficiaries who meet the criteria for assignment to an ACO and had at least one claim with a date of service during the measurement period from an ACO professional who is a primary care physician or who has a specialty designation included at 425.402(c); or who is a Physician Assistant, Nurse Practitioner, or clinical Nurse Specialist. ACOs reporting Medicare CQMs will also report on patients who voluntarily align to the ACO. Reporting on this more limited patient population will reduce burden for ACOs and make for more equitable scoring comparisons as well as limit concerns related to specialty providers being responsible for quality measures outside their expertise by limiting to Medicare FFS beneficiaries meeting the ACO assignment criteria.

CMS will provide ACOs with a quarterly list of beneficiaries eligible for Medicare CQMs in the Quarterly Informational Report Packages. This list will be cumulative and updated quarterly to reflect the most recent quarter's data. The fourth quarter informational packages are typically delivered in February. This list will include other patient information such as age, diagnosis, and encounter and exclusion flags to the extent the information is available through claims and administrative systems.

Like MIPS CQMs, Medicare CQMs can be submitted by the ACO or a third-party intermediary and allow for use of multiple data sources to compile the numerator and denominator. ACOs reporting Medicare CQMs will need to include identifiers that reflect the quality number followed by "SSP" in submission files (e.g., 001SSP, 134SSP, 236SSP).

There will be separate benchmarks established for this reporting type. Because it is a new reporting type, for PY 2024 and 2025 CMS will establish benchmarks using performance period scoring information since they will lack historical data. In PY 2026, CMS will transition to using historical performance to establish a benchmark (as is the case with the other reporting types).
CMS sees the Medicare CQM reporting option as a time limited option and expects the sunsetting of Medicare CQMs will be paced with the uptake of FHIR API technology and assessments of industry readiness. NAACOS is advocating for CMS to make Medicare CQMs a permanent option until all ACOs are able to transition to digital quality measures.

When reporting via Medicare 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). 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 checklist for ACOs on this new reporting option.

***Quality Measure 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. Individual measure benchmarks can be accessed via the CMS website (search 'quality benchmarks' in the Quality Payment Program Resource Library) and are updated annually.

***Data Completeness***

CMS sets data completeness standards through annual rulemaking. For more information access this CMS data completeness resource.

## APP Measure Set for 2024

| eCQM/MIPS CQM/Medicare 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:<br>1. Hospital wide 30-day, all cause unplanned readmission rate | Influenza Immunization |
| | Tobacco Use: Screening and Cessation Intervention |
| | Colorectal Cancer Screening |

| | |
|---|---|
| 2. Hospital admission rates for patients with multiple chronic conditions | 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:<br>1. Hospital wide 30-day, all cause unplanned readmission rate<br>2. Hospital admission rates for patients with multiple chronic conditions |

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