

Quality Reporting at an Inflection Point: Practical Tools and the Path Forward



Pre-conference Workshop

October 14, 2026

Agenda

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- I. History and Current Policy Landscape
 - *Alyssa Neumann & Heidi Bossley*
- II. Practical Tips and Tricks for eCQMs
 - *Wilson Gabbard & Ramsey Abdallah*
- III. Looking Ahead to the Transition to FHIR-based Reporting
 - *Szymon Ryzner*



History and Current Policy Landscape

2019: Quality under Pathways to Success



Quality scaled the savings

Four equally weighted domains (25% each) produced a quality score that multiplied the ACO's maximum sharing rate.

Linked to MIPS, on its own track

ACOs were MIPS APM entities; Web Interface and CAHPS data were reused for MIPS under the APM scoring standard.

23 quality measures

reported via the CMS Web Interface, the CAHPS for ACOs survey and Medicare claims

● Benchmarks

National benchmarks from 2014–2016 Medicare FFS, MIPS and CAHPS data, set in deciles for two years. Flat percentages applied to 10 measures where scores clustered high.

● Minimum attainment

The 30th percentile (or complete reporting for pay-for-reporting measures) earned 1.1 points, rising to 2.0 at the 90th. ACOs had to meet it on at least one measure per domain to share savings.

● Quality improvement points

Up to 4 bonus points per domain for net year-over-year improvement: measures significantly improved minus those declined, capped at the domain maximum.

Seven Years of Quality Policy



2019

Pathways to Success

23 measures via Web Interface; quality score scales savings

2021

APP launches

6 measures; shift to all patient/all payer; required at least a quality score =>30th percentile

2022

Digital on-ramp

Web Interface extended to 2024; created alternative pathways for the quality performance standard

2023

Sliding scale

Fixed the “all-or nothing” scoring; created health equity adjustment

2024

Medicare CQMs

New collection type; last Web Interface year; increase to => 40th percentile

2025

APP Plus

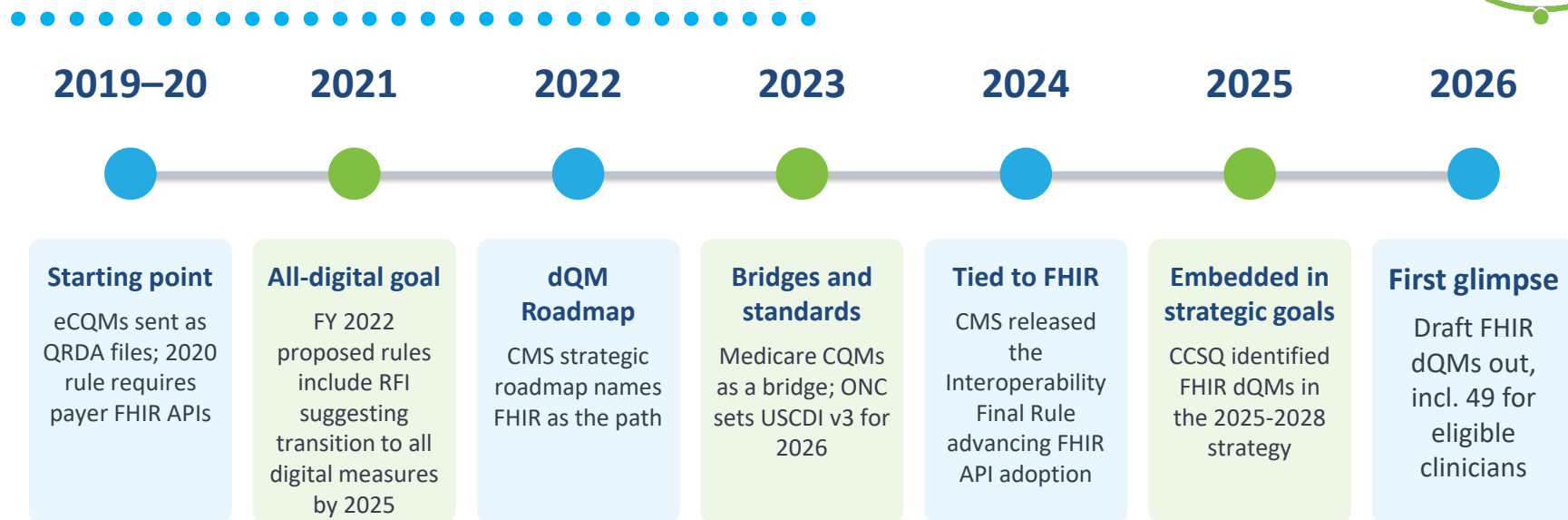
Expanded measure set phases in through 2028; created the complex organizational adjustment

2026

Recalibration

SDOH measure and equity bonus removed

CMS and the Move to FHIR dQMs



Proposed path (CY 2027 PFS RFI): optional FHIR-based reporting in CY 2028, mandatory in CY 2030, starting with a limited set of measures.

NAACOS Advocacy on Quality Changes



2020

2021

2022

2023

2024

2025

2026

Opposing ties to MIPS

Pushed back against CMS proposals to tie ACO quality scores to MIPS quality

Developed initial positions with members

Delay transition

Advocated against abrupt transition to eQCMs/MIPS CQMs

Resulted in extension of Web Interface through PY 2024

Quality and savings

Raised concerns with all-or-nothing approach to quality

Resulted in Alternative QPS for scaled shared savings

New flexibilities

Continued to argue issues of all-payer reporting for ACOs

Resulted in creation of Medicare CQMs

Small wins

Continued advocacy on these challenges

Resulted in extension of eCQM/MIPS CQM reporting incentive, new

Complex Organization Adjustment,

Moving to dQMs

Responded to s RFIs on the transition to dQMs and developed positions on pilot testing

Resulted in renewed engagement with CMS

Big wins

ACO listening sessions with CMS examined in-depth challenges with current reporting framework

Resulted in positive changes proposed for PY 2027

NAACOS continually advocates for fair, accurate, and transparent quality assessments for ACOs

NAACOS Advocacy on Quality Changes



NAACOS 2022 Digital Quality Task Force asks:

What followed:

1 Drop the all-payer requirement for ACO-level eCQM and MIPS CQM reporting



Medicare CQMs (PY 2024) let ACOs report on Medicare patients only; Medicare eCQMs proposed for PY 2027

2 Offset transition costs with incentives so shared savings are not put at risk



eCQM reporting incentive (PY 2022, later extended); sliding-scale alternative standard (PY 2023); Web Interface kept through PY 2024

3 Allow alternative data completeness standards or exclusions for some practices



CY 2027 proposal: ACOs may exclude participant TINs that cannot report, if 95% of beneficiaries stay covered

4 Pilot FHIR APIs with a small group of willing ACOs before any program-wide mandate



Draft FHIR dQMs released (Feb. 2026); CY 2027 RFI floats optional FHIR reporting in 2028 before a 2030 mandate

5 Standardize EHR certification, data elements and patient matching



Still largely open: no national patient identifier, and certification and matching gaps remain

2021: New Reporting Options under the APP



OPTION A

CMS Web Interface

- 10 measures, 7 of them scored
- Medicare beneficiaries only
- Sample of 248 assigned beneficiaries per measure
- Planned to end after 2021; later extended through PY 2024

OR

OPTION B

eCQMs or MIPS CQMs

- 3 measures: HbA1c poor control, depression screening, blood pressure control
- All patients, all payers, across every participant TIN
- 70% data completeness threshold
- Requires aggregating and deduplicating data across EHRs

Plus, for every ACO: CAHPS for MIPS survey + 2 claims measures calculated by CMS (hospital-wide readmission; admissions for multiple chronic conditions)

How the measures were benchmarked

Web Interface

MSSP benchmarks from 2016–2018 Medicare FFS data; flat percentages for 7 measures; 3 measures had no benchmark and went unscored

eCQMs / MIPS CQMs

MIPS historical benchmarks for each collection type, built from 2019 performance data

Scoring

Each measure earned 3–10 points by decile; the total set the MIPS quality score, which had to reach the 30th percentile

2022–2023: On-Ramps to Digital Measures



PY 2022

Buying time

- Web Interface extended through PY 2024
- 40th-percentile standard delayed to PY 2024
- eCQM/MIPS CQM incentive: meet the standard with the 10th percentile on one outcome measure plus the 30th on another

PY 2023

A softer landing

- Sliding scale: partial savings if 10th percentile on one outcome measure
- eCQM/MIPS CQM incentive extended through PY 2024
- Health equity adjustment: up to 10 bonus points
- Signaled that the APP set might expand in the future

Why it mattered:

- Scores would likely reflect payer mix, not quality of care
- Specialist care was included to primary care-focused measures
- Patient matching across TINs and data aggregation was needed - something no one else was required to do
- Certification did not automatically mean the measure was supported
- Data completeness requirement included many inaccurate assumptions
- Cost: 32% expected first-year costs of \$500K or more

2024: Medicare CQMs Arrive



A new bridge opens as the CMS Web Interface closes

1

Medicare CQMs

A new collection type covering only the ACO's Medicare beneficiaries: a bridge for ACOs not ready for all-payer data.

2

Web Interface sunset

PY 2024 was the last year ACOs could report through the CMS Web Interface.

3

40th percentile in force

The full standard took effect, with the eQIM incentive and sliding scale as alternate routes.

2025: APP Plus Phases In



Measure	Collection	Added	Status, Sept. 2026
Q001 Diabetes: HbA1c poor control	eCQM / CQM	2025	Active
Q134 Depression screening and follow-up	eCQM / CQM	2025	Active
Q236 Controlling high blood pressure	eCQM / CQM	2025	Active
Q113 Colorectal cancer screening	eCQM / CQM	2025	Active
Q479 Hospital-wide readmission	Claims	2025	Active
CAHPS for MIPS	Survey	2025	Active
Q484 Admissions, multiple chronic conditions	Claims	2026*	Active
Q112 Breast cancer screening	eCQM / CQM	2026	Active
Q493 Adult immunization status	eCQM / CQM	2027	Proposed removal
Q305 Substance use disorder treatment	eCQM / CQM	2028	Proposed removal
Q487 Screening for social drivers of health	eCQM / CQM	2028	Removed, CY 2026 rule

Suppressed in 2025.

2026: CMS Recalibrates



Key quality changes in response to ACO feedback

● SDOH screening dropped

Q487 removed from APP Plus.

● Equity bonus ended

Health equity adjustment no longer applied starting PY 2026.

● Narrower Medicare CQM attribution

Medicare CQM patients need at least one primary care service in the year.

● Cyberattacks as EUC

Ransomware and malware events qualify for quality relief from PY 2025.

● CAHPS goes web-first

A web-mail-phone survey protocol begins in PY 2027.

PY 2024 Results



How ACOs were scored, by collection type



94%

447 of 476 ACOs met the quality performance standard in PY 2024; the other 29 met the alternative (sliding-scale) standard

Poor HbA1c control (lower is better)

35% → 24%

Controlling high blood pressure

70% → 74%

Depression screening & follow-up

44% → 55%

ACOs outperformed similar physician groups on depression screening (53.5% vs. 44.4%) and blood pressure control (71.2% vs. 67.8%).

Digital reporting was still the minority: 167 ACOs submitted eQMs, MIPS CQMs or Medicare CQMs, and 91 of them also submitted through the Web Interface, where CMS used the higher score.

How ACOs met the standard: 390 at the 40th percentile, 122 through the eCQM incentive and 59 as first-year ACOs (some qualified more than one way).

All-payer reporting advanced: 72 ACOs reported all-payer measures in PY 2023, nearly double the year before.

Audience Questions



- *Who participated in MSSP under the previous framework?*
- *What were your experiences (e.g., benefits or challenges of Web Interface reporting)?*
- *What were the outcomes, whether positive or negative, of this transition for your ACO?*

Current State of ACO Quality for 2027



- CMS has shown a commitment to transitioning all quality reporting programs, including ACOs to digital reporting methods
 - Medicare Shared Savings Program (MSSP) includes two options for electronic reporting (and two alternative options)
 - Long-term Enhanced ACO Design (LEAD) Model phases in two eQMs
- New policies show receptivity to ACO advocacy positions
 - ✓ Phase-in of eQMs in LEAD, starting with optional reporting and pay-for-reporting before performance-based measurement
 - ✓ Options to report on only ACO-assigned patients
 - ✓ Flexibilities in data completeness requirements for ACOs
- **Audience questions**
 - *Who is planning on participating in MSSP for 2027?*
 - *Who is planning on participating in LEAD for 2027?*
 - *Has anyone never reported quality in MSSP?*

MSSP Quality for 2027



- APP Plus Quality measure set:
 - Controlling High Blood Pressure
 - Diabetes A1c Poor Control (>9%)
 - Screening for Depression & Follow-up
 - Breast Cancer Screening
 - Colorectal Cancer Screening
 - Hospital-wide Unplanned Readmissions
 - Admissions for Patients with Multiple Chronic Conditions
 - CAHPS for MIPS Survey
- Quality Performance Standard: 40th percentile of MIPS quality (73.85 for PY 2026)
 - eQCM/MIPS CQM reporting incentive QPS: 10th percentile of one outcome measure and 40th percentile of any other measure
- Alternative QPS: 10th percentile for one outcome measure; shared savings scaled based on performance

*If finalized as proposed:

- Reporting options:
 - eQCMs (all payer/all patient)
 - MIPS CQMs (all payer/all patient)
 - Medicare CQMs (ACO assigned patients)*
 - Medicare eQCMs (ACO assigned patients)*
- ACOs can report multiple pathways and will receive the higher score on a per-measure basis
- Complex Organization Adjustment: up to 1 point added per eQCM reported
- Flat benchmarks for Medicare CQMs and Medicare eQCMs*
- Data completeness: TIN-level exclusion by measure when data cannot be accessed; TINs submitted must represent 95% assigned beneficiaries*

Is the ACO in the 1st performance year of its 1st agreement?

No

Yes

Did the ACO report the full APP Plus set, meet data completeness on all eCQMs/MIPS CQMs/Medicare CQMs and CAHPS for MIPS and receive a MIPS Quality performance category score?

No

ACO not eligible for shared savings

Does the ACO's final quality score (+any applicable adjustments) meet/exceed the 40th percentile of MIPS quality performance?

No

Yes

QPS met – ACO eligible for maximum shared savings

Did the ACO report all eCQMs/MIPS CQMs in the APP Plus set and meet data completeness?

Yes

Did the ACO report the full APP Plus set and achieve a score $\geq 10^{\text{th}}$ percentile of benchmark (decile 1) for at least 1 outcome measure AND achieve a score $\geq 40^{\text{th}}$ percentile of benchmark (decile 4) for at least 1 remaining measure?

Yes

QPS met – ACO eligible for maximum shared savings

No

Did the ACO report the full APP Plus set and achieve a score $\geq 10^{\text{th}}$ percentile of benchmark (decile 1) for at least 1 outcome measure?

No

No

ACO not eligible for shared savings

Yes

Alternative QPS met – ACO eligible for lower shared savings scaled by performance

Pathways to Meeting the Quality Performance Standard

LEAD Model Quality for 2027



- Quality measure set:
 - All-Condition Readmissions
 - Unplanned Admissions for Patients with Multiple Chronic Conditions
 - Days at Home for Patients with Complex, Chronic Conditions
 - Timely Follow-up After Acute Exacerbations
 - LEAD CAHPS Survey
 - Controlling High Blood Pressure eCQM (optional for PY 27-28)
 - Diabetes A1c Poor Control >9% eCQM (optional for PY 27-28)
- Quality Withhold = 3%, earned back based on Total Quality Score
- Total Quality Score Calculation:
 - Initial Quality Score = based on each measure score (worth 10 points each)
 - dQM/eCQM Reporting Adjustment (PY 27-28) = 1.25% per eCQM
 - PQP Reporting Adjustment = up to 5% (up to 10% in PY 29-36)
 - CI/SEP criteria (beginning PY 28)
 - High Performers Pool (beginning PY 28)

CMS notes ACOs will be able to report as eQMs or dQMs, but does not provide detail on dQM reporting

NAACOS dQM Positions & Recommendations



- ACOs should be able to leverage a broad set of digital data (not limited to the EHR) that is seamlessly integrated to support multiple use cases, including quality measurement and clinical decision support
- CMS must allow for flexibilities to enable ACOs to get to dQMs and we anticipate it will take at least 5 years from the time FHIR dQMs are available to fully transition to successful dQM reporting; necessary steps to get to dQMs
 - Need adequate time for vendors to incorporate technical requirements into products
 - Robust education and technical assistance at the clinician, practice, health system, and ACO levels
 - Must incorporate requirements into ONC certification criteria
 - Must support Bulk FHIR
 - Pilot testing to ensure accuracy of results and feasibility across types of ACOs is necessary before tying to any payment
 - Glidepath to requirements and pay-for-performance must include incentives to support ACOs and practices through each step of the transition

Transition to dQMs



- CMS is committed to transitioning to FHIR-based digital quality measurement but still needs key feedback from industry on how to get there
 - In 2022, NAACOS convened a Digital Quality Task Force to develop recommendations on eCQMs
 - In 2025/2026, NAACOS developed new positions on FHIR-based dQM through Clinical & Quality Committee for response to CMS RFIs
 - 2026 ACO Quality Survey gathered detailed feedback from members
 - Report coming out November 2026
 - A handful of members have been working with Leavitt Partners to pilot test FHIR-based dQMs; we are exploring whether to formalize a partnership with LP or to facilitate a NAACOS-led pilot
- **Goal:** develop detailed recommendations on transition to FHIR-based dQM for ACOs and create educational materials to support ACOs in preparing for the transition

2026 ACO Quality Survey



Quality Survey Background

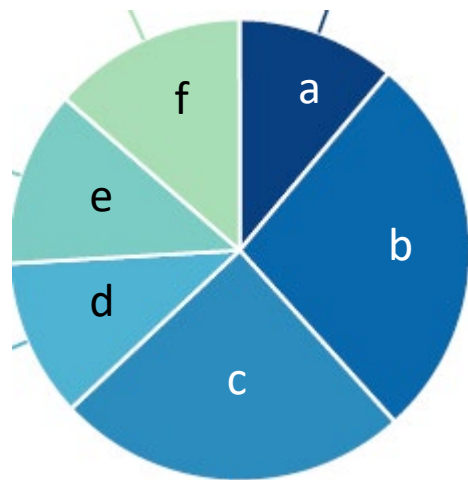


- NAACOS conducted a 2021 survey of ACOs' feedback on the transition to eCQMs/MIPS CQMs
- Summer 2026 NAACOS updated this survey to assess experiences with the transition to current reporting options and readiness for FHIR-based reporting
- 81 organizations responded, representing over 240 unique ACO contracts
- Included feedback in response to CMS RFI on transition to FHIR dQMs
- Detailed survey report to be published November 2026

EHR Vendor Usage

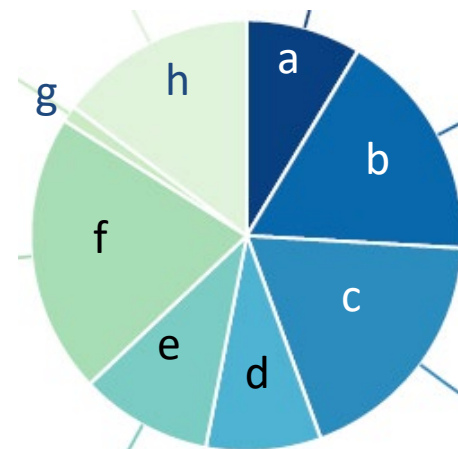
- Distinct EHR vendor systems used

- a. 1 – 11%
- b. 2-5 – 27%
- c. 6-10 – 25%
- d. 11-15 – 11%
- e. 16-25 – 12%
- f. >25 – 14%



- Instances of EHRs used

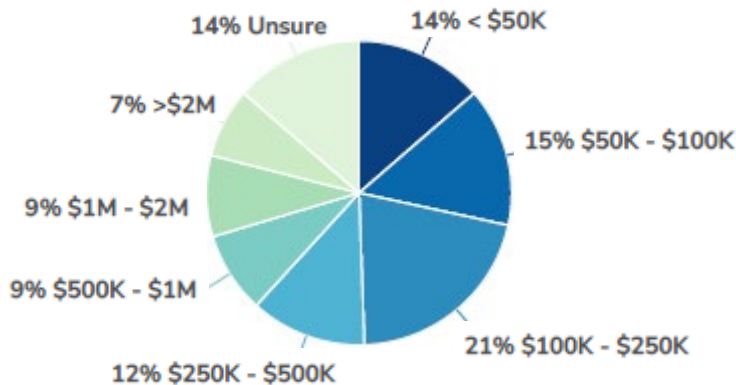
- a. 1 – 9%
- b. 2-5 – 17%
- c. 6-10 – 19%
- d. 11-15 – 9%
- e. 16-25 – 10%
- f. 26-45 – 21%
- g. 45-75 – 1%
- h. >75 – 15%



Experiences with Transition from Web Interface

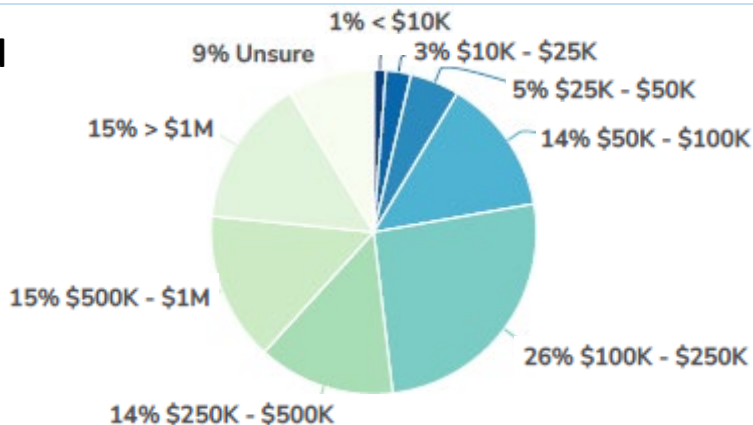


Estimated additional cost to transition



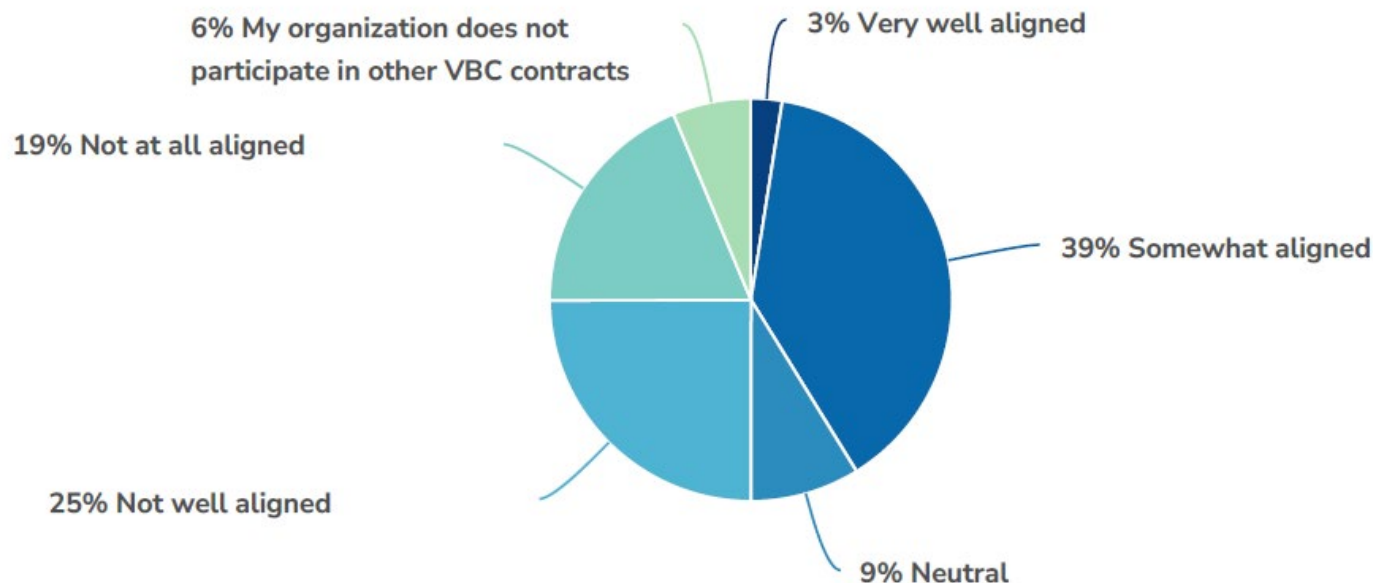
- ACOs that had to remove practices due to the transition:
 - 40% of respondents had to remove practices, largely due to inability to generate required QRDA files for eCQM reporting
 - Over 540 practices removed
 - Nearly 3,000 clinicians removed
 - 230 small practices
 - 334 specialty practices
 - 24 rural practices

Estimated annual cost for reporting

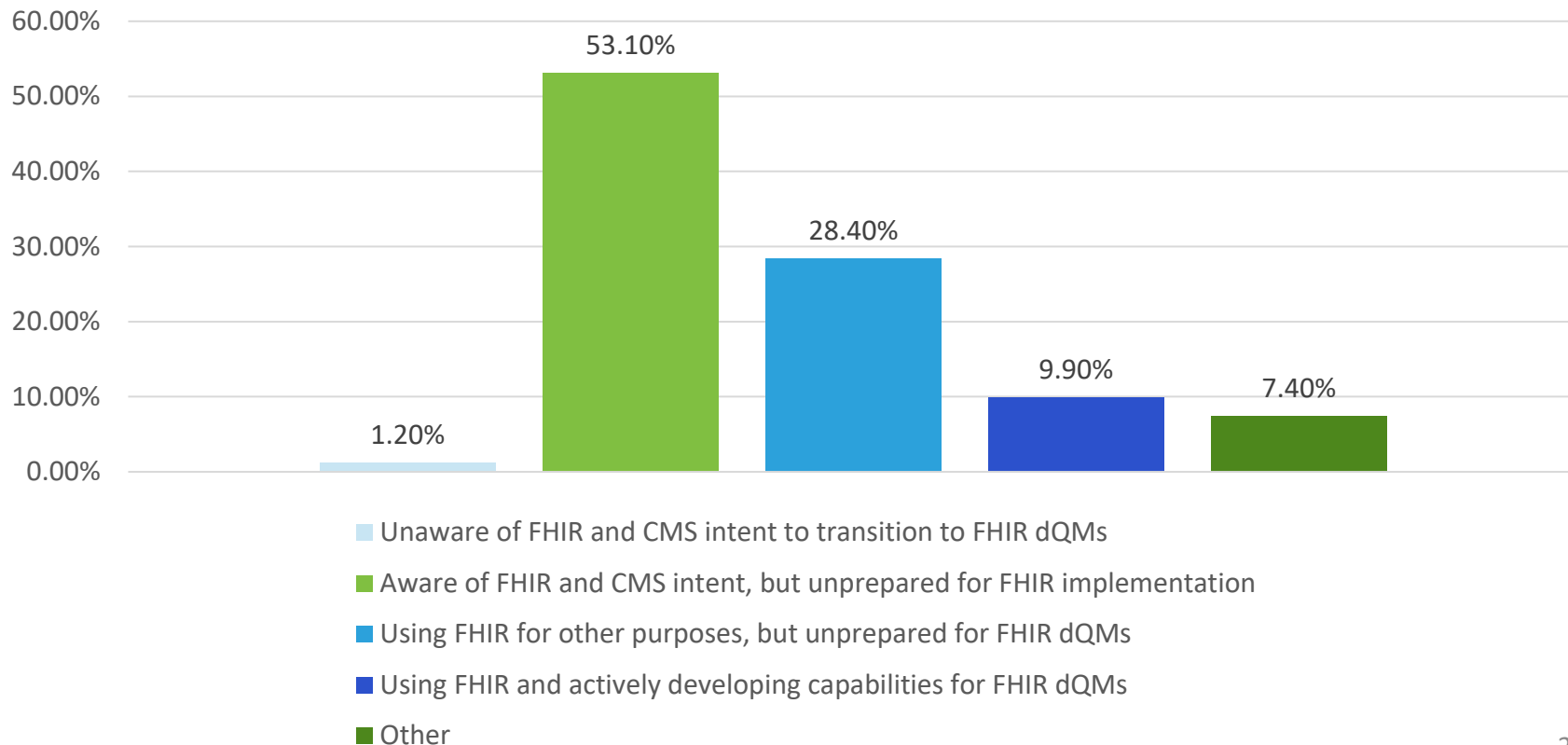


Alignment with Other VBC Contracts

- How well do the quality reporting processes for your Medicare ACO align with the work on reporting for other value-based care contracts?*



Current State of Familiarity with FHIR and dQMs



Anticipated Benefits and Challenges of FHIR dQMs



Top reported expected benefits:

1. Less manual reporting
2. More automated and integrated data sharing
3. Improved data availability and timeliness
4. Better monitoring of performance across TINs
5. Ability to use data for additional use cases (e.g., quality improvement, clinical decision making)

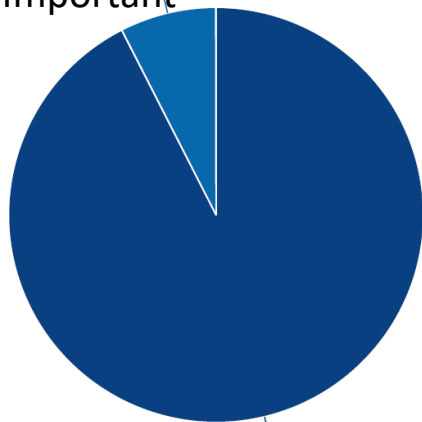
Top reported expected challenges:

1. Cost of investment and ability to sustain participation within current model incentives
2. Vendor timelines and capabilities
3. Lack of internal technical capabilities
4. Lack of adequate CMS/ONC guidance and support
5. Data validation and testing efforts

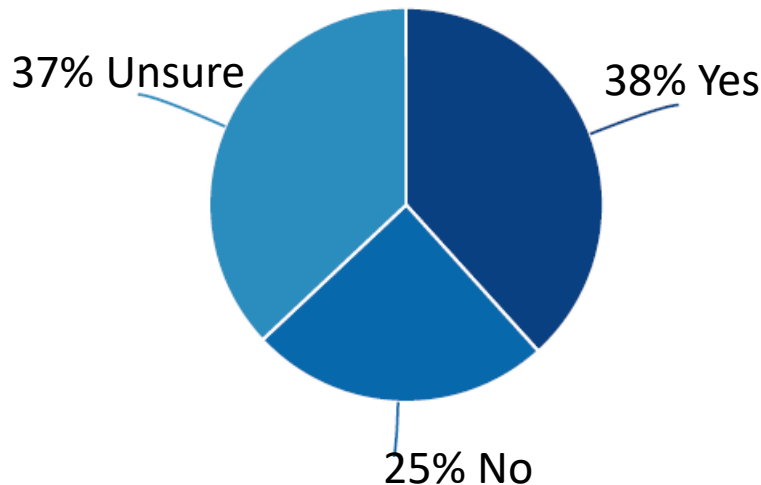
Pilot Testing

- *How important is it that CMS provide a dedicated testing and validation period before FHIR dQMs count towards ACO quality performance for shared savings?*
- *Would your organization be interested in participating in a pilot program testing FHIR-based quality reporting for ACOs?*

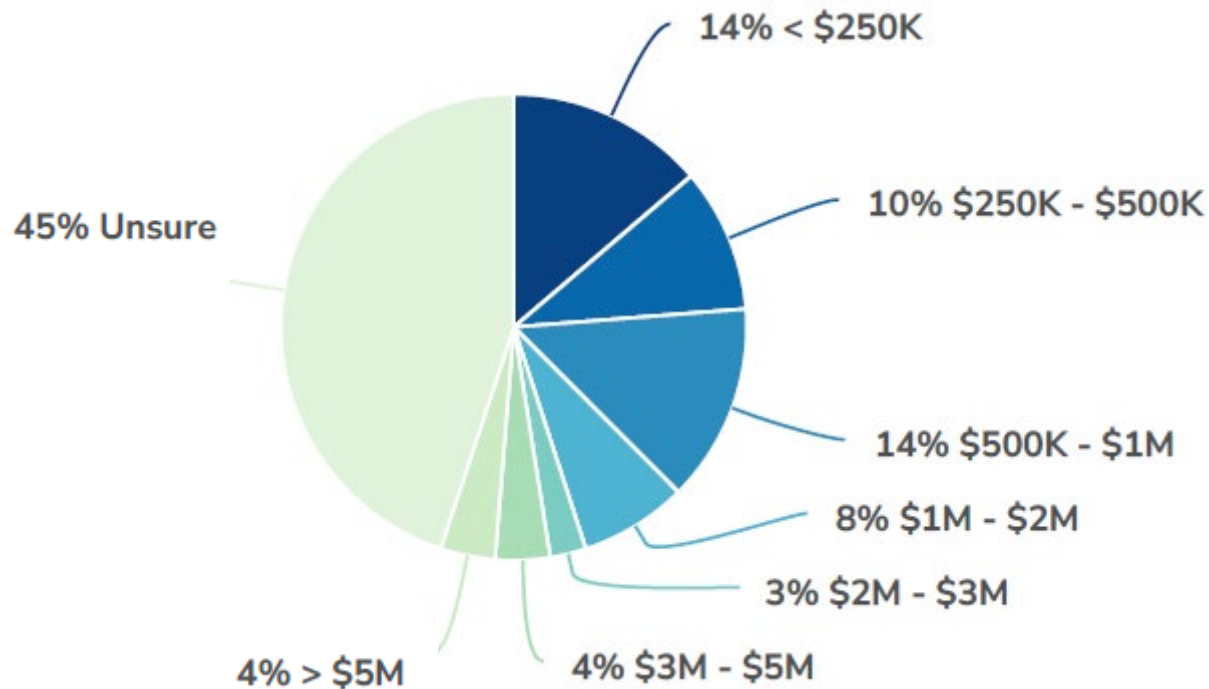
7% Very Important



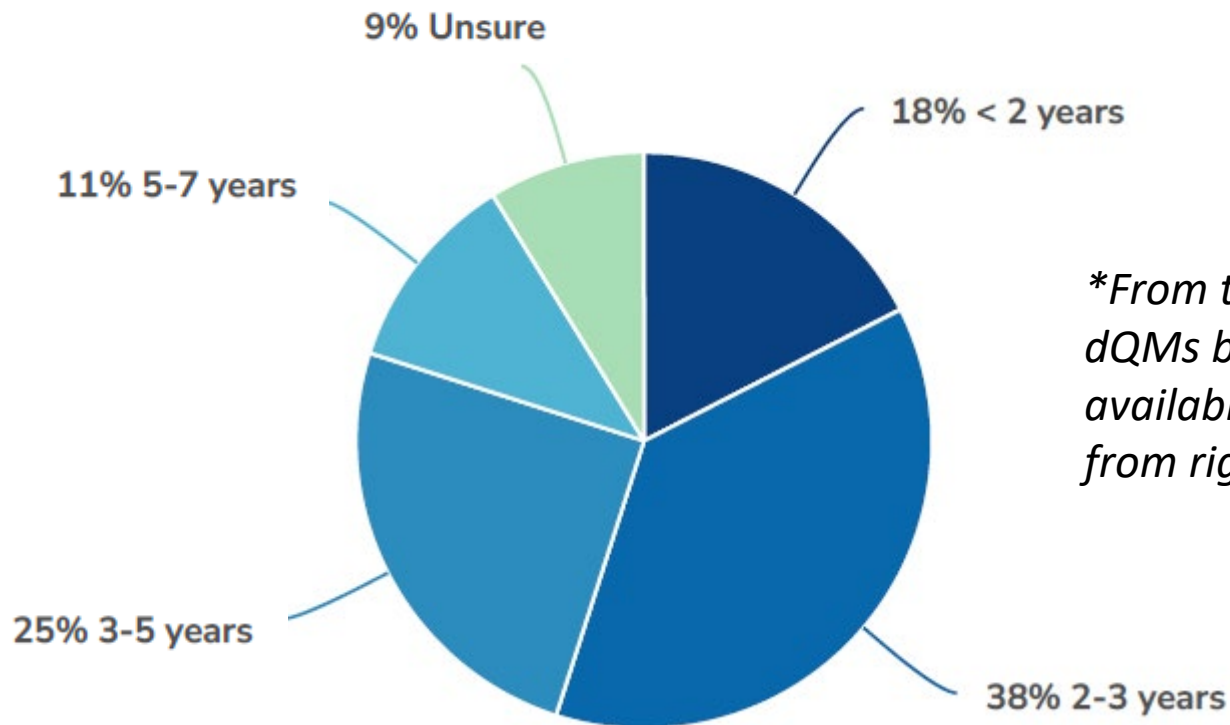
93% Critical



Anticipated Upfront Cost to Implement FHIR dQMs



Anticipated Timeline to Implement FHIR dQMs



**From the time FHIR dQMs become an available option, not from right now*

Most Valuable Technical Assistance



1. Measure-by-measure dQM implementation support
2. FHIR implementation guides and tutorials
3. Data mapping and terminology standardization assistance
4. Vendor engagement, enforcement, and coordination support
5. Data validation and quality assurance tools

Most Helpful Flexibilities and Incentives



1. Phase-in of performance-based assessment (i.e., pay for reporting) without duplicate reporting requirements
2. Limiting required reporting to ACO-attributed patients
3. Lower quality performance standard during initial period of performance-based assessment
4. Financial incentives for practices to fund necessary infrastructure upgrades
5. Smaller set of measures required in initial years

Next Steps



- *What are your organizations doing now to start facilitating this transition?*
- *Are there other advocacy priorities for CMS/ONC in this space NAACOS should be addressing?*
- *What additional educational resources would you want to see from NAACOS? From vendors? From CMS/ONC?*

Practical Tips and Tricks for eCQMs



Value Based Services Platform

Managing Health, Quality and Total Cost of 2.3M Lives



26K+

Participating
Physicians



13

Networks | ACOs | CINs



2.3M

Managed Lives



2 of 7

CMS ACO REACH
Health System
Participants
in the Nation



131

Value-Based
Contracts



\$1.9B

Total value created



72

Participating
Hospitals

Value-based care success built on capabilities fine-tuned over decades of experience managing shared savings, shared risk, professional and global capitation across CMS, commercial and Medicaid contracts.



Network Management



Value Innovation



Data Management Infrastructure



Advanced Analytics

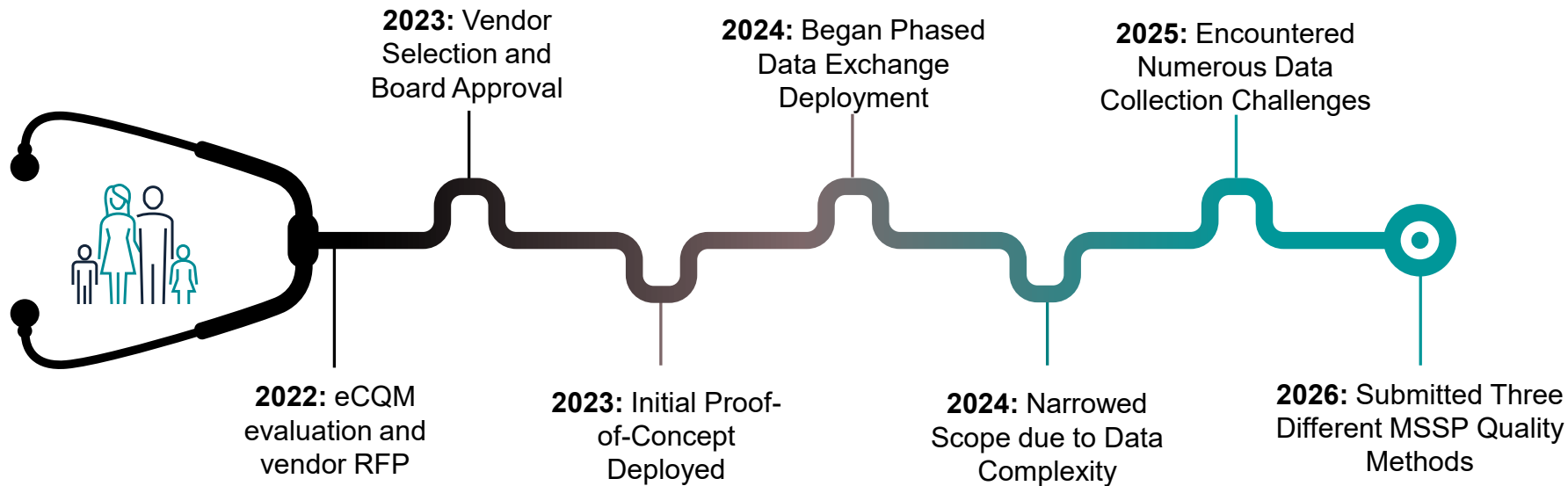


Clinical Programs



TPA/MSO

Quality Reporting Journey



1,312

Measures Across Contracts

\$294M

Quality Contingent Revenue Managed

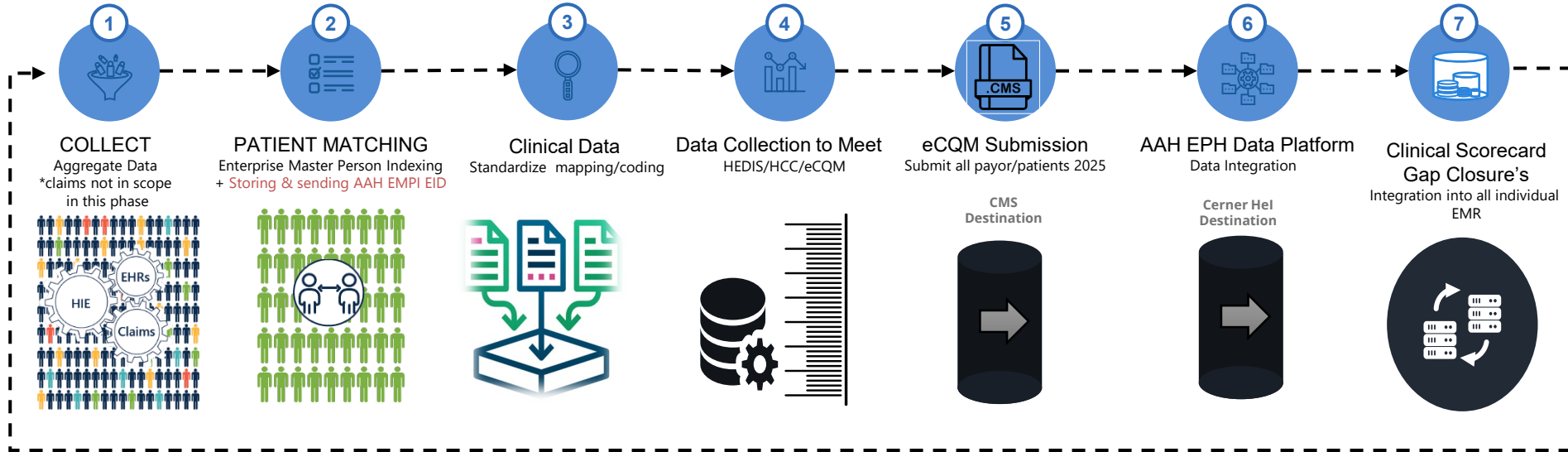
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Unique Quality Measures

EMR Data Exchange Platform Components

7 Components Required

The framework below describes the functionality and vendor capabilities needed to support EMR data retrieval, standardization, submission, and multiple integration architectural designs.



Data Management

Data Governance | Data Management | Data Delivery
Data Standardization

Technology

Security & Privacy



Vendor Selection

REQUIREMENTS:

- Ability to connect and exchange data with multiple EMR providers
- Vendor to maintain codified mapping values for each instance. Data is secured at rest and in transit
- eCQM/MIPS CQM certified submission of clinical data for eCQM requirements
- Ability to interface with AAH EMPI system
- Outbound extract and ingestion

Vendor	Score	Notes
Vendor A	27	Primary drivers: Price and data collection
Vendor B	24	Primary drivers: eCQM experience and User Interface for validation
Vendor C	X	Did not offer the full end to end processing, only standardization and calculation.
Vendor E	X	Only focused on eCQM.
Vendor F	X	They use a third party to do data acquisitions.
Vendor G	X	They would rely on another vendor to do the eCQM Submission.

Evidence from the Field - FHIR Implementation

- 171 unique EHR instances, Advocate only received FHIR from 3 EHRs, 14 instances.
- Some FHIR sources did not include data to support all measures (ie. depression screening measure)
- Augmented data with QRDA
- We attempted to obtain FHIR sources for 22 instances of one EMR, after 6+ months of failed attempts, pivoted to QRDA
- **Advocate is in favor of using a standard FHIR implementation across all EHRs**
- **We need ONC to ensure EHRs are able provide usable/standardized data**



Quality Reporting Implementation Priorities

Define a strategy that supports implementation to support improved outcomes



Begin with the end in mind

Defining the vision for DQM to **support patient outcomes, not just checking a box** is likely the most important decision you will make as an ACO executive implementing mandatory reporting



Orchestrate Collaboration

Optimizing data to improve outcomes, requires substantial technical orchestration and considerable investment



Drive Program Optimization

Get involved with sharing your experience. We will be the recipients of something done to us, vs helping shape what can be done to support us if we don't get involved

Population Impact

Prioritize
Improvement

Align with Contracts

Drive Enterprise
Alignment

Improve Health
Outcomes

Align Resources

Practice Readiness Assessment for eCQMs

READINESS CHECKS

01 Data submission

Confirm each practice TIN is on CEHRT and can send data for eCQM reporting.

02 All patients/all payer data

Confirm the practice can send data for all patients across all payers.

03 Workflow and data capture

Review practice workflows and how teams capture the data needed for eCQMs.

FOLLOW-UP ACTIONS

04

Initial assessment tracking

Track providers who did not pass the initial readiness assessment.

05

Action plan for unresolved items

Create an action plan to address each outstanding readiness gap.

System Configuration for eCQM Data Ingestion

A vendor or the ACO can configure the system and process the data.

01

Interface configuration

Configure interfaces to ingest practice data into the reporting system.

02

Create and build measures

Code mapping

Map codes to measure concepts.

Inclusions and exclusions

Set population eligibility rules.

Lookback periods

Define the time windows for each measure.

03

Outcome processing

Apply the configured measure logic to calculate the numerator and denominator.

Data Validation for eCQM Reporting

The most critical and most time-consuming step

01 Primary source verification

Check a subset of records against the original source.

02 Code sets and proprietary codes

Evaluate code sets and map proprietary codes to support measure processing.

03 Outcomes and data quality

Assess outcomes and validate the quality of the data.

04 Issue identification

Work with practices and vendors to identify issues.

05 Gap closure and process mapping

Address the gaps to improve quality.

POSSIBLE CAUSES TO INVESTIGATE

Low denominators

Missing data may reduce the denominator.

Poor outcomes

Required workflows may not be followed.

Specialty relevance

The type of service may not be relevant to the specialty.

Quality Data Submission and Ongoing Monitoring

Ongoing monitoring of the ACO's submission is critical

01 Submit quality data

Use QRDA III for the eCQM file submission.
Confirm the correct ACO ID and reporting period.

02 Clarify submission responsibility

Name the submitter and the ACO reviewer.
Align responsibilities with the vendor.

03 Monitor through completion

Review submission status and reported results.
Resolve errors and unexpected submissions.

VENDOR SUBMISSION

Confirm eligibility

CMS-approved QCDRs and Qualified Registries can submit on an ACO's behalf.

Keep ownership clear

Large ACOs face greater risk of confusion about responsibilities. Confirm the designated submitter and monitor the ACO's submission directly.

Quality Reporting Documentation for ACOs

Suggested documentation checklist

01 Governance and oversight

Document accountable owners, approval responsibilities and oversight decisions.

02 Data collection process

Record data sources, collection workflows and completeness checks.

03 Data aggregation

Describe how practice data combine and which measure versions apply.

04 Deduplication

Define patient-matching rules and how teams resolve duplicate records.

05 Reporting and validation

Retain validation results, corrections, approvals and submission evidence.

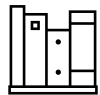
06 Vendor management

Document vendor responsibilities, agreements and performance reviews.

07 Data security

Maintain security policies, access controls, risk assessments and incident procedures.

Challenges and Burdens



Measure Sets

Lack of standard measure sets across different payers and programs creates duplication of effort and burden



Measure Specifications

Each payer, contract and program implementing differing measure specifications for the same measure creates burden and confusion – this also includes differences in scoring logic, data sources and population definitions



Benchmarks

Each payer, contract and program has their own set of benchmarks. Tracking performance against different benchmarks is duplicative and burdensome



Performance Feedback

Quality performance feedback is often shared months or even more than a year following the quality action – this doesn't offer the opportunity to provide actionable insights at the point of care



Data Collection

Retrieval of medical records from disparate EMR's and external systems creates significant burden. Each payer, contract and program may ask for the data to be submitted in a different manner. This can lead to need for multiple vendors and teams to support reporting similar measures to different payers/programs, creating inefficiencies and burden.



Changing Requirements

Quality reporting and scoring requirements change annually, creating significant burden to continually need to track, interpret rules, reassess and update approaches to quality reporting.

Recommendations

Adopt a CMS Core Measure Set

Focusing on 10-15 high impact measures across Medicare programs like MSSP, MA, LEAD, etc.

Impact

Allows health systems to focus efforts and reduce duplication and burden that comes with reporting different measures across contracts and programs

Encourage Payers to Align with Core Measure Sets

Encouraging payers to align around a common, core measure set. This could be done through policy incentives for those that adopt CORE measure sets, as an example.

Impact

Allows health systems to focus efforts and reduce duplication and burden, allowing for increased focus on quality improvement efforts

Encourage Adoption of Common Measure Standards

Encouraging adoption of common measure specifications and standards across the industry.

Impact

Reduces burden associated with tracking different versions of the same measure

Reduce Use of Retrospective Scoring

Moving toward more real-time data with monthly performance visibility.

Impact

Creates actionable data that can be used to improve patient care, rather than retrospective data that is used for scoring purposes only.

Reduce Administrative Complexity

Reducing changes to rules and requirements annually.

Impact

Allows health systems to build on expertise gained and focus and invest in one path for quality reporting.

Align Industry Around Digital Reporting Approaches

Align the industry around digital reporting approaches and standards used for digital reporting.

Impact

Provides for one clear path forward, allowing health systems to invest in the tech and infrastructure that will be needed to adopt the next generation of digital quality measures and reporting.

Move to Digital Quality Aspirations



Reduce Waste

Move to DQM, with CMS and ONC support will substantially reduce administrative waste



Expand Participation

Quality reporting should encourage value-based care participation

More Proactive

Better data supports prevention to identify risks earlier, before it happens



Streamlining interoperability for better health

Reduce Burden

Promoting true bi-directional interoperability will reduce clinician burden



Top Policy Changes Needed

1. Need EHR vendors to produce industry standard files as part of CERT requirements
2. Need CMS reporting flexibility on data completeness



Questions & Answers

Quality Reporting at an Inflection Point: Practical Tools and the Path Forward

Lessons from multi-EHR eCQM implementation

Ramsey Abdallah, DHA / Northwell Health

Practical implementation segment

One practice can mean four TINs and five EHR instances

4

tax IDs

5

EHR instances

The reporting path must work for each relevant TIN, EHR instance, and measure.

A vendor name or a single “certified EHR” answer cannot resolve that matrix.

A two-part reporting needs assessment

ASK THE PRACTICE

Map TINs, NPIs, sites, and EHR instances.

Show where staff enter each measured fact.

Name the extract owner & authorize vendor contact.

ASK THE EHR VENDOR

Confirm measure year, build, and output.

Provide a test file and workflow guide.

State frequency, cost, and escalation contact.

Illustrative	CMS 165 (BP)	CMS 122 (A1c)	CMS 2 (Depression)
TIN A / EHR Instance 1	✓ Proven	✓ Proven	⚠ Untested
TIN A / EHR Instance 2	● Blocked	● Blocked	● Blocked
TIN B / EHR Instance 1	✓ Proven	⚠ Untested	✓ Proven

Join answers by TIN, EHR instance, and measure. Mark each path proven, untested, or blocked.

An EHR vendor claim becomes useful when the output is demonstrated

01	Measure support	Measure year, software build, certified module, and instance
02	Test output	A sample patient-level file or approved data for the reporting route generated from production or production-mirror environment
03	Workflow map	A vendor click path or configuration guide for data capture
04	Operating terms	Refresh frequency, build cost, named owner, and escalation route

For an eCQM path, test the QRDA I export when that is the chosen collection route.

Data exchange needs its own owner and test

01

Authorize

Confirm sharing terms, approved recipient, and the minimum data needed.

02

Configure

Choose an approved portal or encrypted transfer route. Name sender and receiver.

03

Prove receipt

Send a test file, capture acknowledgment, and define how failures escalate.

Run this work alongside vendor testing. A finished extract still needs a safe delivery route.

A received file still needs validation

Check	Compare	Red flag	Next check
Coverage	Expected TINs, NPIs, and periods	Missing site or reporting month	Check export roster
Matching	Patient identifiers across sources	Unmatched or duplicate people	Audit matching rules
Denominator	Eligible patients by measure	Unexpected change in volume	Segment by site
Logic	Sample numerator and exclusion cases	Care in an unmapped field	Trace mapped field
Continuity	Before and after an EHR change	Break in the trend	Compare before / after

Practice education turns a measure defect into a workflow fix

When a chart shows the care but the measure does not:

01

Review cases

Compare charts with the vendor workflow guide and mapped fields.

02

Teach the step

Update the job aid and train the role that owns documentation.

03

Retest

Rerun the extract and confirm the intended change appears.

The same discrete data can support other contracts, with measure definitions checked separately.

Measure reach can change integration priorities

Which EHR connection should the ACO tackle next?

01

Assigned lives

How many ACO beneficiaries rely on this EHR?

02

Eligible cases

How many cases does it add for the chosen reporting route?

03

Delivery effort

Can the vendor deliver and sustain usable data?

Sequence integrations by coverage and feasibility; meet reporting requirements throughout.

	High Measure Coverage Impact	Low Measure Coverage Impact
Low Delivery Effort	Start here	Schedule next
High Delivery Effort	Plan phased delivery	Assess an approved alternative

The same reporting controls support LEAD and FHIR

2026 MSSP

APP Plus uses measure-specific eCQM, MIPS CQM, and Medicare CQM options.

LEAD in 2027–28

BP and diabetes eCQM/dQM reporting is optional for aligned Medicare beneficiaries.

Data submission

FHIR API and HDR Excel are primary LEAD routes. Existing QRDA users have a 2027–28 bridge.

Keep the controls: identity, deduplication, field mapping, secure exchange, and validation.

Policy status: CMS's 2027 MSSP changes remain proposed.

Practical takeaways for the next reporting cycle

01	Inventory by TIN, EHR instance, and measure.	Tool 1
02	Prioritize integrations by measure reach and feasibility.	Tool 6
03	Get practice and vendor evidence of output and workflow.	Tools 2 & 3
04	Set up secure transfer and patient matching early.	Tools 3 & 4
05	Validate, teach, and retest after every major change.	Tools 4 & 5

Where would this onboarding plan fail first?

A new specialty practice joins with two TINs and two EHR instances. The vendor says “eCQM ready.” No sample file or secure delivery route has been tested. The first BP rate looks unusually low.

At your table, agree on:

**Ask the practice one question and request one proof item from its vendor.
Choose a validation check, an owner, and the first deadline.**

ACO eCQM Readiness Assessment Toolkit

Practical Resources for the Transition to Digital Quality Reporting

**Download the checklist
using the QR code:**

- or -

[Access the link here](#)





Looking Ahead to the Transition to FHIR-based Reporting

➤ *Szymon Ryzner, VillageMD /
Summit Health*

FHIR Integration

An evaluation of connectivity milestones, quality data limitations, and recommended technical paths forward.

What is FHIR

- **Fast Healthcare Interoperability Resources (FHIR)**, created by HL7 International
- RESTful APIs with JSON and XML outputs
- Granular / modular building blocks for data sharing
 - Patient
 - Observation
 - Encounter

Why FHIR?

- HL7v2
 - Point-to-point
 - Lack of standardization
- HL7v3
 - Pros
 - Web-native
 - Granular queries
 - Cons
 - Overly rigid
 - Complex
- Broad EMR Support
 - Federally Mandated
 - ONC 21st Century Cures Act
 - 107.315(g)(10)

Why Now?

- Leavitt and CMS exploring migration to dQM reporting via FHIR
- Why did we join the effort?
 - Deploy FHIR at the enterprise level
 - Relatively straightforward EMR ecosystem
 - HL7 experts on Rhapsody
 - Share learnings with others

Summit Current State

Data Environment

- Majority of patients in Athena with subset in Epic
- Data from both EMR environments populate Snowflake
- Rhapsody integration engine manages HL7 and API feeds in and out of both EMRs

Quality Reporting

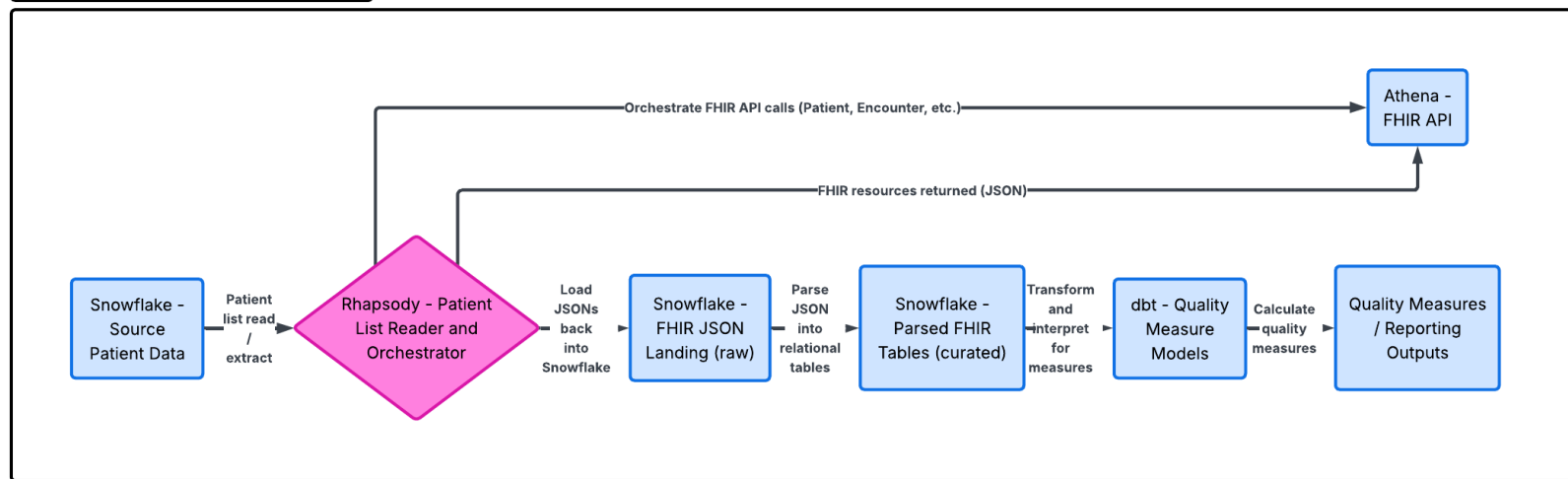
- eCQM reporting generated out of Athena instances by the vendor
- Depending on volumes Epic instance population is also tabulated and compared-against

Athena-Specific Workflow

Reporting

- Athena pulls eQCMs on our behalf out of the EMR
- Athena has a suite of internally developed API's (not FHIR)
- Athena also supports FHIR API's

Athena FHIR Integration: Snowflake to Rhapsody to Athena



FHIR Based Results v Current Process

FHIR

- We have pulled patient demographics, encounters, conditions, coverages, medications, observations and procedures via Athena FHIR API
- We've ingested all of the data but we were unable to calculate any quality measures due to environment limitations
- Attempting to pull data directly from production via FHIR but met with EMR vendor roadblocks

Results

- We have not been able to calculate quality measure results across Athena FHIR data products

FHIR Challenges

- Networking
 - IP whitelisting on Summit and Athena
- Connectivity
 - Permissions controlled in Athena by service user
 - Separate processes for upper / lower environment access
- Authentication
 - Key / secret authentication into FHIR endpoints
- Unable to reliably compute dQMs using standalone FHIR API Responses today
 - Multiple calls required to pull all information needed for a measure
 - 10,000 patients could be upward of 70,000 API calls
 - JSON output requires cleanup and normalization in order to calculate measure performance for validation

Considerations

- How does your current eCQM reporting ecosystem look?
- Do you have internal resources that could build FHIR interfaces?
- Are your EMRs and/or other vendors ready for this potential migration to FHIR-based quality reporting?