



eCQMs, MIPS CQMs and Medicare CQMs



Agenda

.....



- Overview of eCQMs, MIPS CQMs and Medicare CQMs – Jennifer Gasperini, NAACOS
- Overview of the Medicare CQM proposal in the proposed 2024 Medicare Physician Fee Schedule (MPFS) rule – Tim Jackson, CMS
- How ACOs are moving forward – discussion with Travis Broome, Aledade, Jess Walradt, Northwestern Medicine and David Basel, Avera Health

MSSP Quality Reporting

- CMS implemented a number of changes to quality requirements for MSSP through the APM Performance Pathway (APP)
- The APP aligns MSSP quality reporting and scoring with MIPS policies
- This includes retiring the Web Interface reporting option in 2025 (report data early 2026)
 - Alternatives = eCQMs, MIPS CQMs or the newly proposed Medicare CQM reporting options

NAACOS Resources

- NAACOS [Quality Resource](#)
- Digital Quality Measurement [Task Force Paper](#)
- NAACOS Guide to [Accessing eCQM Specifications](#)

CMS Resources

- MSSP [APP Guidance](#)
- QPP [Resource Library](#)
 - See APP Toolkit

eCQMs, MIPS CQMs and Medicare CQMs



eCQMs	MIPS CQMs	Medicare CQMs (proposed)
Report data directly from Certified EHR Technology (CEHRT) using QRDA III	Flexibility in reporting	Flexibility in reporting
All originating data must come from CEHRT - no abstraction, manual manipulation or supplementation <ul style="list-style-type: none"> CMS assumes 100% data completeness 	Flat files, registry, EHR; abstraction permitted <ul style="list-style-type: none"> 75% data completeness 	Flat files, registry, EHR; abstraction permitted <ul style="list-style-type: none"> 75% data completeness
Benchmarks are lower compared to MIPS CQM (recognizing the lack of flexibility in data collection)	Benchmarks higher than eCQMs (recognizing more flexibility provided in data collection)	Benchmarks unknown – will use performance year data to establish BMs in PY 2024 and 2025, historic BMs thereafter *only ACOs permitted to report, therefore BMs expected to be high
Reporting on all patients/all payer data	Reporting on all patients/all payer data	Report on Medicare patients meeting MSSP assignment criteria
Aggregate data across ACO participant TINs and do patient matching/de-duplication before submitting aggregate level data to CMS		

Challenges



Measures do not apply to attributed patients only – this brings in specialties often not appropriate for the measure

Data must be aggregated and reported at the ACO level (across all TINs, all EHRs)

**eCQM/MIPS CQM
Reporting at the ACO
Level**

The all-payer requirement requires reporting on all patients meeting the denominator criteria (Medicaid, self pay, etc.)

ACOs must identify a way to de-duplicate patient data/do patient matching

Data Completeness

.....

- Data completeness = the volume of performance data reported for the measure's eligible population
- You must report performance data (performance met or not met, or denominator exceptions) for the data completeness threshold specified for the eligible population (denominator)

Proposed 2024 MPFS Rule



- **New Medicare CQM reporting option for PY 2024**
 - Time limited, transitional option reporting MIPS CQM measures on a more limited patient pop.
 - Limits reporting to Medicare patients meeting ACO assignment criteria
 - Limits scoring challenges with the all-payer approach used in eCQM/MIPS CQM reporting (equity concerns, specialty provider concerns)
 - Still requires substantial work in aggregating/de-duplication efforts
- NAACOS continues to ask CMS to resolve these issues in the long-term by addressing the eCQM and MIPS CQM reporting options

Medicare CQMs



CMS proposes to define a beneficiary eligible for Medicare CQMs at §425.20 as a beneficiary identified for purposes of reporting Medicare CQMs who is either of the following- A Medicare FFS beneficiary who:

- Meets the criteria for a beneficiary to be assigned to an ACO; and
 - Had at least one claim w/ a DOS during the measurement period from an ACO professional who is a primary care physician or who has one of the specialty designations included at §425.402(c); or who is a PA, NP or CNS
- A Medicare FFS beneficiary who is voluntarily aligned to the ACO

Medicare CQMs



(c) ACO professionals considered in the second step of the assignment methodology in paragraph (b)(4) of this section include physicians who have one of the following primary specialty designations:

- (1) Cardiology.
- (2) Osteopathic manipulative medicine.
- (3) Neurology.
- (4) Obstetrics/gynecology.
- (5) Sports medicine.
- (6) Physical medicine and rehabilitation.
- (7) Psychiatry.
- (8) Geriatric psychiatry.
- (9) Pulmonary disease.
- (10) Nephrology.
- (11) Endocrinology.
- (12) Multispecialty clinic or group practice.
- (13) Addiction medicine.
- (14) Hematology.
- (15) Hematology/oncology.
- (16) Preventive medicine.
- (17) Neuropsychiatry.
- (18) Medical oncology.
- (19) Gynecology/oncology.

Medicare CQMs



Medicare CQM Patient List - CMS will provide ACOs with a list of beneficiaries eligible for Medicare CQMs within the ACO, once annually at the beginning of the quality data submission period

- ACOs would need to ensure all beneficiaries that meet applicable Medicare CQM specifications and also meet the definition of a beneficiary eligible for Medicare CQMs under §425.20, are included in the ACO's eligible population/denominator for reporting each measure
- CMS plans to share certain patient information along with technical assistance to ACOs when reporting Medicare CQMs
- NAACOS is advocating for CMS to require reporting only for the patients on the CMS list provided at the beginning of the reporting period

Medicare CQM Patient Data Shared w ACOs:

- Gender
- Beneficiary identifier
- DOB (and death if applicable)
- Chronic condition subgroup
- NPIs of the top three frequented providers in the ACO
- Health status information (ex, risk profile)

Medicare CQMs



- ✓ **Measures-** Report the 3 MIPS CQM measures, on a more limited patient population
- ✓ **Benchmarks-** would be created based on performance year data for PY 2024 and PY 2025
- ✓ **Data completeness-** 75%
- ✓ **Patient List/Report-** CMS will provide ACOs w/ a list of eligible patients at the start of the reporting period
 - ACOs will need to ensure all patients that meet the applicable Medicare CQM specifications and also meet the definition of a beneficiary eligible for Medicare CQMs are included in the ACO's eligible patient population (denominator) for reporting each measure

Proposed MSSP Quality Updates



- MPFS rule proposal would update quality measure set for PY 2025- to align with new Universal Foundation set
 - Would add composite vaccination measure, Substance Use Disorder treatment measure and Social Determinants of Health screening measure
 - Some of these measures could be added to the eCQM, MIPS CQM and/or Medicare CQM measure sets in the future

Reviewing Medicare Clinical Quality Measures for the Shared Savings Program as proposed in the CY 2024 Medicare Physician Fee Schedule Proposed Rule

September 21, 2023

Tim Jackson
Director, Division of Quality and Price Transparency
Performance-based Payment Policy Group
Centers for Medicare and Medicaid Services



Overview

Our proposals address changes to the Shared Savings Program regulations to further advance Medicare's overall value-based care strategy of growth, alignment, and equity.

We proposed changes to the quality performance standard and reporting requirements under the Alternative Payment Model (APM) Performance Pathway (APP) within the Quality Payment Program (QPP) that would continue to move ACOs toward digital measurement of quality and align with the QPP.

Major proposals include:

- **Establishing the Medicare Clinical Quality Measure (CQM) for ACOs Participating in the Shared Savings Program (Medicare CQMs) as a new collection type for Shared Saving Program ACOs under the APP.**
- Removing the certified electronic health record technology (CEHRT) use threshold requirements and requiring reporting of the Merit-based Incentive Payment System (MIPS) Promoting Interoperability performance category for all tracks of the Shared Savings Program.
- Using historical data to establish the 40th percentile MIPS Quality performance category score.
- Establishing Shared Savings Program scoring policy for excluded APP measures.





Medicare CQM Proposals

For performance year 2024 and subsequent performance years, we're proposing to establish Medicare CQMs as a new collection type for Shared Saving Program ACOs within the APP measure set.


- A Medicare CQM is a CQM reported by an ACO on Medicare patients, including beneficiaries voluntarily aligned to the ACO, with claims encounters with ACO professionals with specialty designations used in the Shared Savings Program assignment methodology during the quality measurement period.
- CMS would provide ACOs with a partial list of the beneficiaries who are eligible for Medicare CQMs within the ACO.
- ACOs must meet same data completeness standard as established/proposed under MIPS; benchmarks would be developed in alignment with MIPS benchmarking policies.
- ACOs that report Medicare CQMs would be eligible for the health equity adjustment to their quality performance category score



Medicare CQMs: Approach and Considerations



As presented in the 2024 Physician Fee Schedule Proposed Rule*



Medicare CQMs would serve as a transition collection type to help some ACOs build the infrastructure, skills, knowledge, and expertise necessary to report all payer/all patient MIPS CQMs and eCQMs by defining a population of beneficiaries that exist within the all payer/all patient MIPS CQM specifications and tethering that population to claims encounters with ACO professionals with specialties used in assignment.

We encourage ACOs to evaluate all quality reporting options to determine which collection type is most appropriate based on the ACO's unique composition and technical infrastructure.

* <https://www.federalregister.gov/d/2023-14624/p-1472>





Medicare CQMs: How to Learn More



- To better understand assignment methodologies, please review to the Medicare Shared Savings Program [SHARED SAVINGS AND LOSSES, ASSIGNMENT AND QUALITY PERFORMANCE STANDARD METHODOLOGY Specifications January 2023 Version #11 Applicable to Performance Years Starting on January 1, 2023, and Subsequent Years.](#)
- To learn more about data aggregation expectations and guidance, please review the [Medicare Shared Savings Program: Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Pathway](#) (guidance document) or the [CMS YouTube](#) (video presentation)





Past, Present, and Future Medicare Quality Reporting Decisions

Northwestern Medicine ACO's Experience





Northwestern Medicine

- *1 AMC located in downtown Chicago*
- *2 multi-specialty employed group practices (~2800 employed physicians)*
- *11 hospitals*

Northwestern Medicine ACO

- *~82,000 assigned beneficiaries*
- *45 practices*
- *16 EMRs*

Quality Reporting Considerations

Performance Score

- Is the measure data accurate?
- Is the measure data reflective of the quality of care delivered?
- Is performance inappropriately skewed by factors out of physician control? (e.g. payer mix, specialty mix, etc.)
- Is performance assessed against an accurate, fair benchmark?

Reporting Mechanics

- Type of data collection
- Level of automation
- Level of requisite maintenance
- Scope
- Cost/Resource intensity
- Frequency

ACO Attributes Drive Approach to Quality Reporting



**Attributed
Population Size**



**Number of Disparate
EMRs**



**“System Function”
Resourcing**



Number of Practices



**Profit Status &
Ownership Structure**



**Historical
Investments**



**Patient Distribution
Across Practices**



Payer Mix



Funding Priorities



**Percent Employed
Physicians**



**Clinician Specialty
Mix**



Culture

NM's eCQM Experience to Date

2021

- Did not want to spend money solely for the purposes of submitting data
- Inexperienced vendors
- Existing relationships with independent practices via CIN Quality Team
- 10 Epic Connect practices

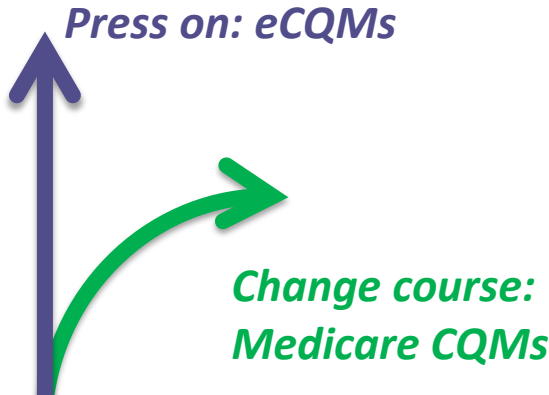
Decision: Pursue eCQMs

Today

- **93%** of practices produced QRDA files
- **84%** of files successfully ingested into NM Epic

Future Decision: eCQMs vs. Medicare CQMs

Next Step: Decision Point



Consideration	eCQMs	Medicare CQMs
Work Invested to Date	✓	
Collection Burden	—	— *
Alignment with Future Quality & Interoperability Policy	✓	
Data Completeness Threshold		✓
Impact of Payer Mix on Performance		✓
Impact of Specialty Mix on Performance	—	—

* Depends on finalized policies; CQM collection could end up creating additional burdens

PFS Final Rule – Key Guidance and Policy Revisions



Medicare CQM Duration: Encourage CMS to clarify that Medicare CQMs will be a reporting option through X date



Medicare CQM Population: Winnow to MSSP attributed or proxy attributed population



Application of Policies to eCQMs: Apply Medicare CQM data completeness threshold to eCQMs

Thank you!

Measuring Quality

Why and How?

Travis Broome, MPH, MBA
SVP of Policy & Economics





Quality Measurement Only Matters if it is Accurate



Census – Measure Everyone

A perfectly done census is the most accurate; however, a census is time consuming, expensive and reliant on automation.

Bias occurs when the process of the census introduces it.



Sampling – Measure a Random Subset

Sampling is faster, much less expensive, and allows for manual review of the medical chart. Nearly all health care research is done through sampling

Bias occurs when the sample is not representative of the population.

Current MSSP is a Mix of Census and Sampling

Claims Measures *Census*

Medicare already collects all the data needed for a census for other reasons

Bias is introduced because populations are compared that are not similar

Risk adjustment attempts to remove this bias with limited success

CAHPS Survey *Sample*

CMS creates a sample and requires a 3rd party administrator

Long history in design of survey to remove bias within an ACO

Bias is introduced because populations are compared that are not similar

Web Interface *Sample*

CMS creates a sample and the ACO administers

Potential bias in differences in ACO administration

No bias found in sample

Bias is introduced because populations are compared that are not similar



Moving Clinical Measures to a Census

Requires full automation

Introduces significant bias from the wildly variable processes from ACO to ACO

Expanding the population increases the bias when comparing ACO to benchmarks

What Automation for 44 MSSP ACOs means at Aledade

Costs are largely variable though Aledade does enjoy economies of scale.

91 Different EHRs

1,438 practices with 3,556 locations and 14,731 clinicians serving 1.4 million beneficiaries

STARS, HEDIS, and

Some require claims, some use variation of measures, little crossover

~\$4 million in indirect

Over 20 team members at Aledade
Much more FTE load in the practices



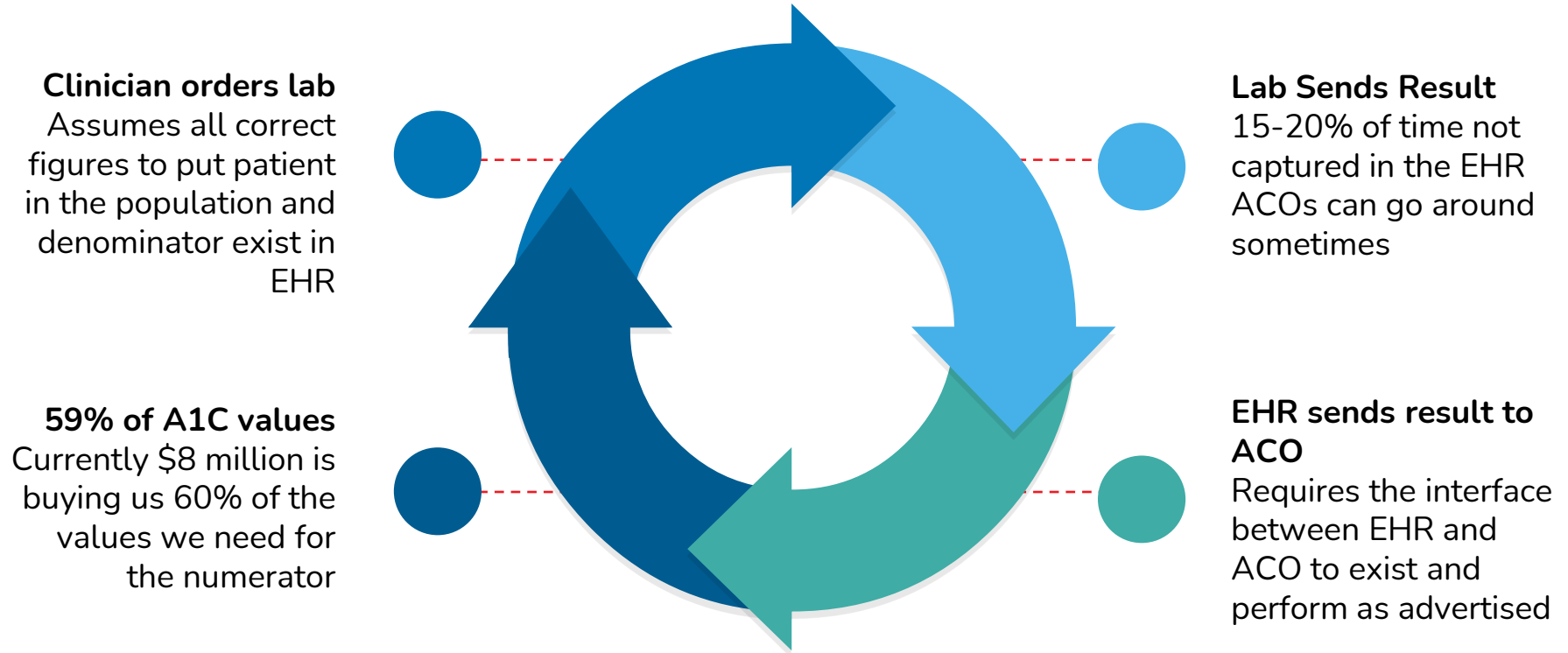
~40 Lab Interfaces

30 Health Information Exchange Interfaces

~\$4 million in direct

EHR interfaces and QM vendor fees

Life Cycle of a Single Patient A1c x Hundreds of thousands of times



Every step includes multiple data points that can fail and every failure is irreversible in a census, but discoverable and potentially remedied in a sample



Commenters, including ACOs, expressed concerns that the requirement to report all payer measures ties performance to patients that the ACO does not actively manage, increases the difficulty of meeting data completeness, and may negatively impact an ACO's performance by including patients seen by specialists.

CMS 2024 Physician Fee Schedule Proposed Rule





37

ACUTE CARE
HOSPITALS

200

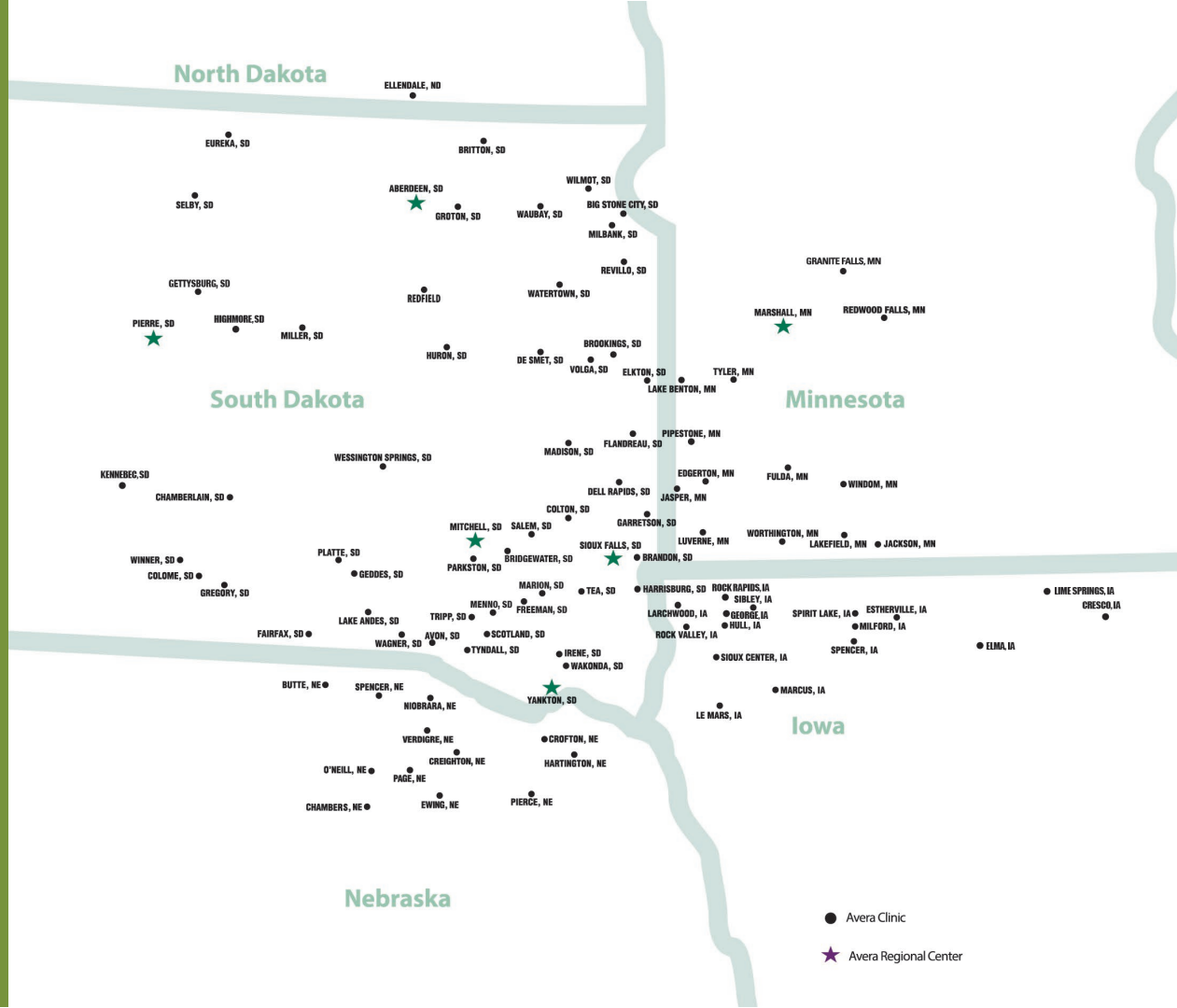
OUTPATIENT
CLINICS

26

avera@home
LOCATIONS

40

LONG-TERM CARE
ASSISTED LIVING &
RETIREMENT
COMMUNITIES



● Avera Clinic

★ Avera Regional Center

Avera

CQM Decisions



Buy vs Build

3rd Party Vendor / Registry vs In-House



eCQM vs MIPS/ACO CQM

Can we get all the way to eCQM yet



MIPS vs Medicare CQM

All Payer vs Medicare only

CQMs

Buy vs Build

Possible Choice: Buy

- Ease of Implementation / Turnkey Solutions
- Accuracy / Reliability
- Still require data extracts / transfer to vendor
- Incredibly Expensive (Opportunity Cost)

Possible Choice: Build

- IT infrastructure / resources adequate?
 - 90% on single instance EMR
 - Experienced Data Repository Team
- Knowledge / expertise adequate?
 - Partners such as NAACOS

CQMs

eCQM vs MIPS/Medicare

Possible Choice: eCQM

- Long-term goal but are we there yet?
- Integrated system with hospital VBP journey as well
- Owned/Leased/Managed Participants likely ready
- Many smaller independents and specialty groups unlikely to ever be able to do this (expertise, cost)
- Are we prepared to jettison some of our partners (they may do better in traditional MIPS anyway)?

Possible Choice: MIPS or Medicare CQM

- Better allows blending of disparate sources
- Allows our IT department to adapt extracts
- Even allows manual abstraction if necessary
- ?Wasted effort if going to eCQMs anyway

CQMs

MIPS vs Medicare CQMs

Possible Choice: MIPS CQMs

- All payer – don't have to worry about attribution
- More predictable benchmarking
- How does our payer mix compare vs other ACOs?

Possible Choice: Medicare CQMs

- Narrower population = less work deduplication
- Uncertainty of attribution procedure
- Benchmark Bingo

CQM

Decisions

- **Submit Web Interface as long as possible**
Ensure at least one accurate and reliable method

- **Build Internally**
Rely on collaboration

- **MIPS vs Medicare CQMS**
Not ready to jettison independents
Maybe submit both as learning?

Thank You!

Avera 
Moving Health *Forward.*