

# NAACOS Digital Quality Measurement Task Force



# TF Members.....



Task Force Chair	Dr. Katherine Schneider
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Summit Medical Group	Dr. Ashish Parikh
Advocate Aurora	Megan Reyna
Mount Sinai	Maria Alexander and Dr. Rob Fields
Aledade	Dr. Josh Israel
Northwestern	Jess Walradt
Coastal Carolina Quality Care	Stephen Nuckolls
Bellin Health Partners ACO	Chris Elfner
Evolent	Jessica Landin
The Ohio State Health ACO	Dr. Aaron Clark and Lindsey Bryan
Atlantic ACO	Dr. James Barr

# Overview



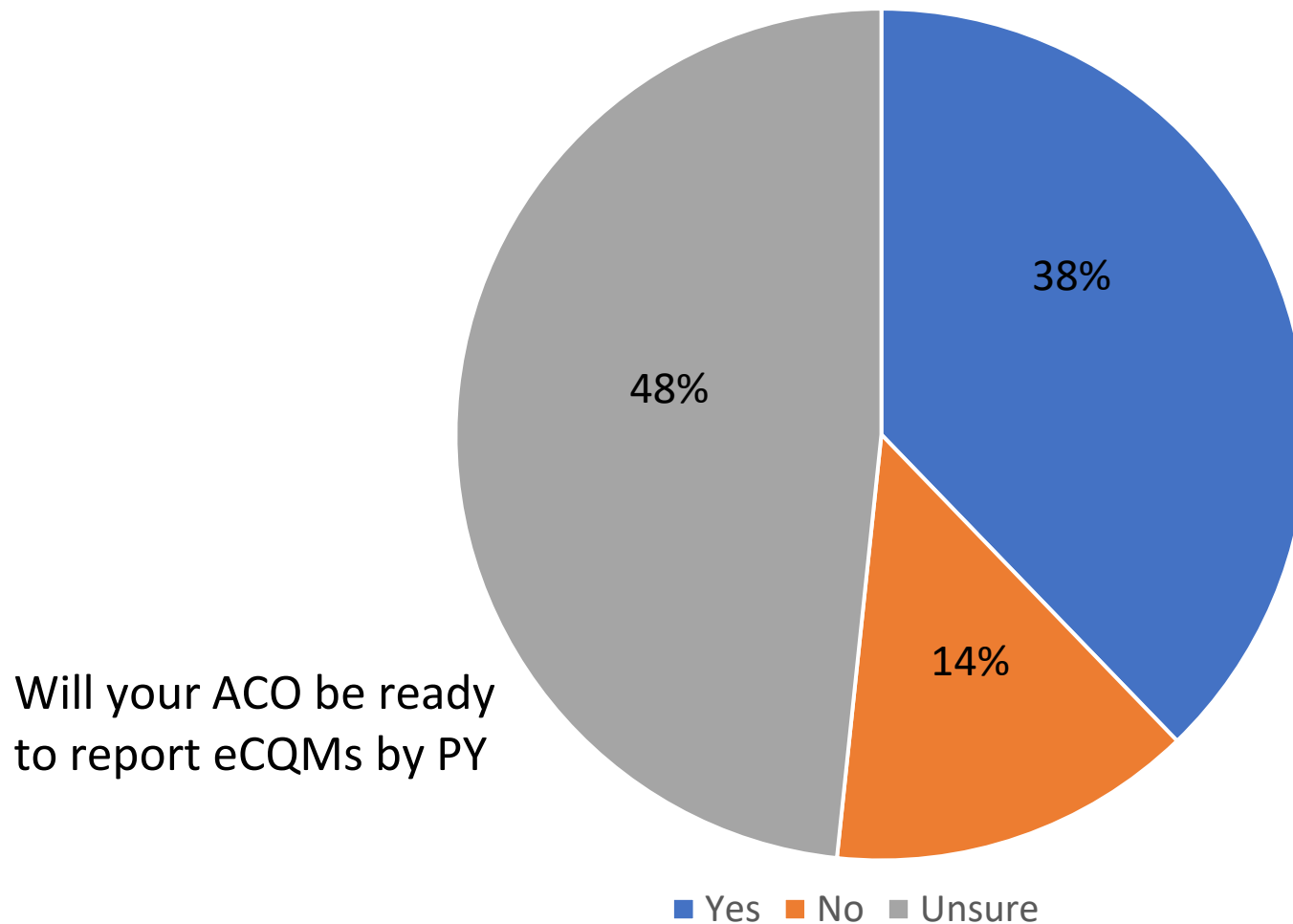
- While efficient, technology-enabled quality reporting is the future we strive towards, current changes to the MSSP quality program go far beyond simply digitizing the previous well-established process, and will have the unintended consequence of increasing administrative burdens, and rewarding/penalizing ACOs on factors unrelated to the quality of care provided to beneficiaries.
- The MSSP program-wide P4P implementation of the eCQM program should not move forward without proof-of-concept of both technical readiness AND impact of the shift to all-payer / all-patient measurement.
- We offer several specific solution recommendations for acceleration of technology readiness, reduction of administrative burden, and avoidance of unintended, harmful consequences.



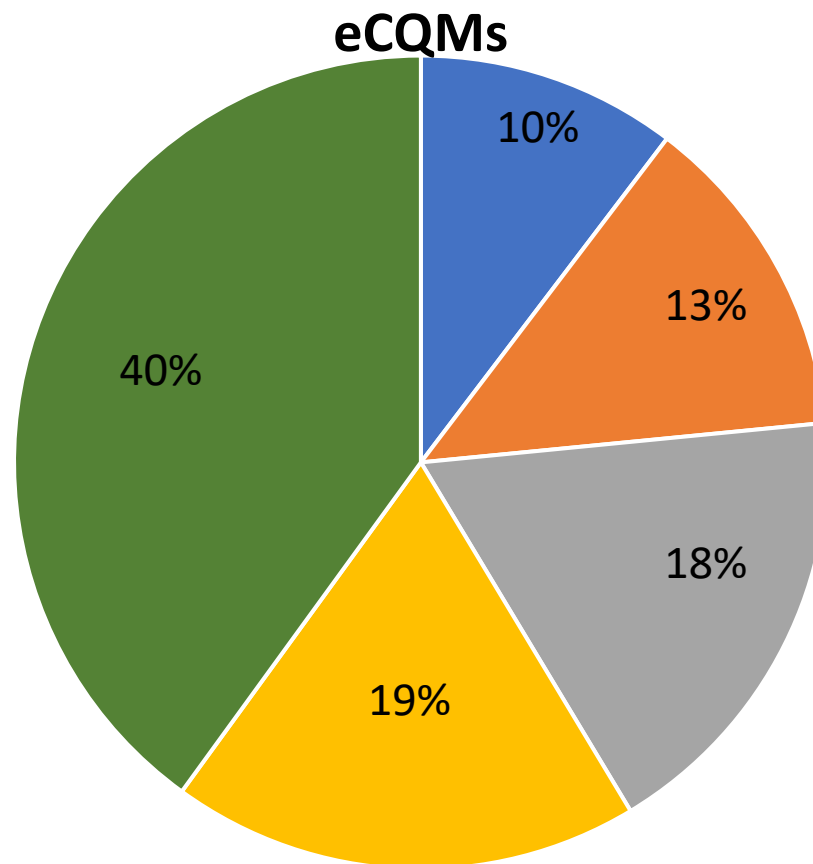
# NAACOS 2022 eCQM Survey Highlights



## 62% of respondents say they will not be ready to report eCQMs or are unsure if they can report eCQMs by 2025



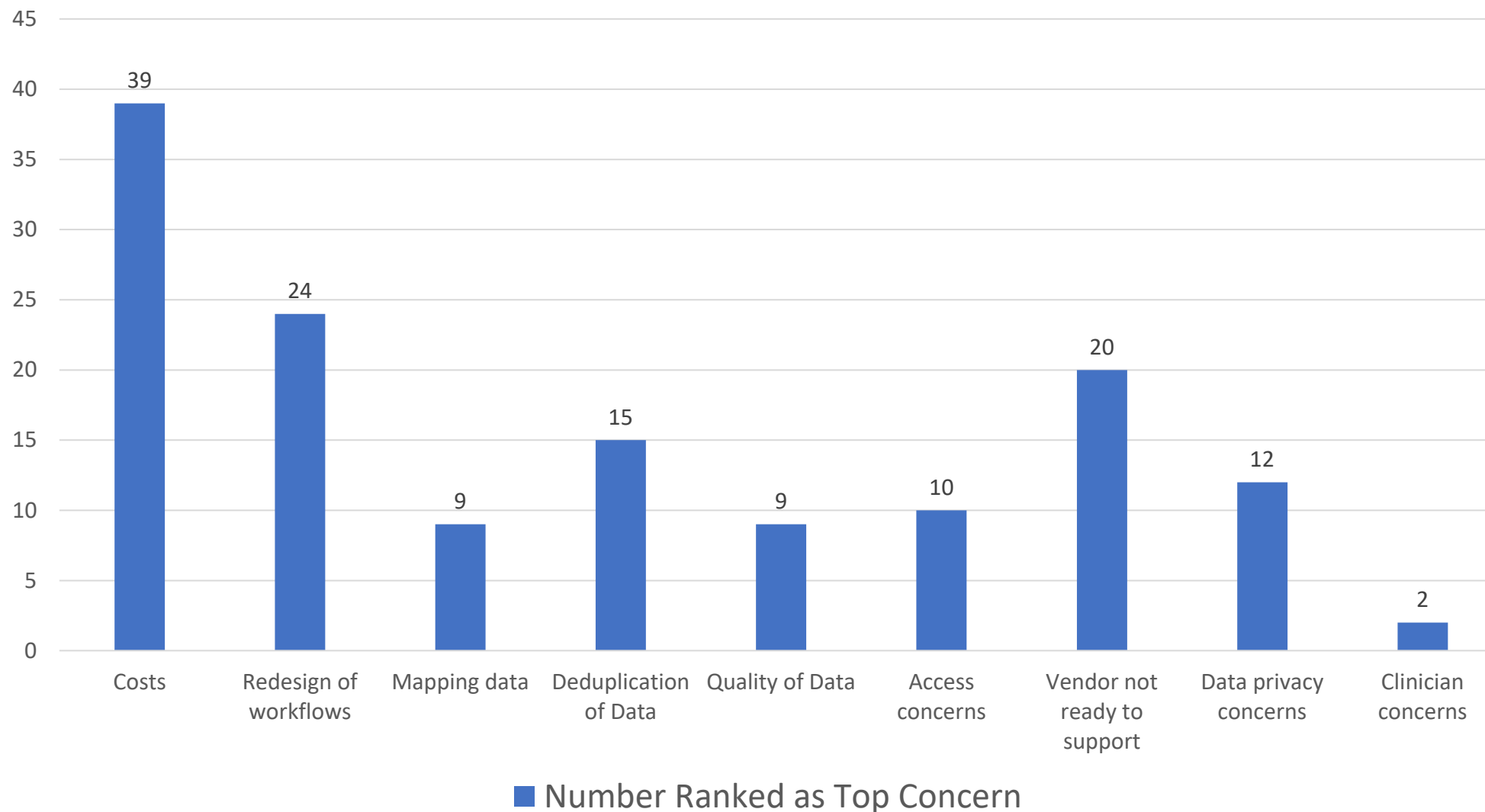
**10% of respondents plan to report eCQMs in 2022, 13% in 2023 and 18% in 2024 while 40% are unsure when they will report eCQMs**



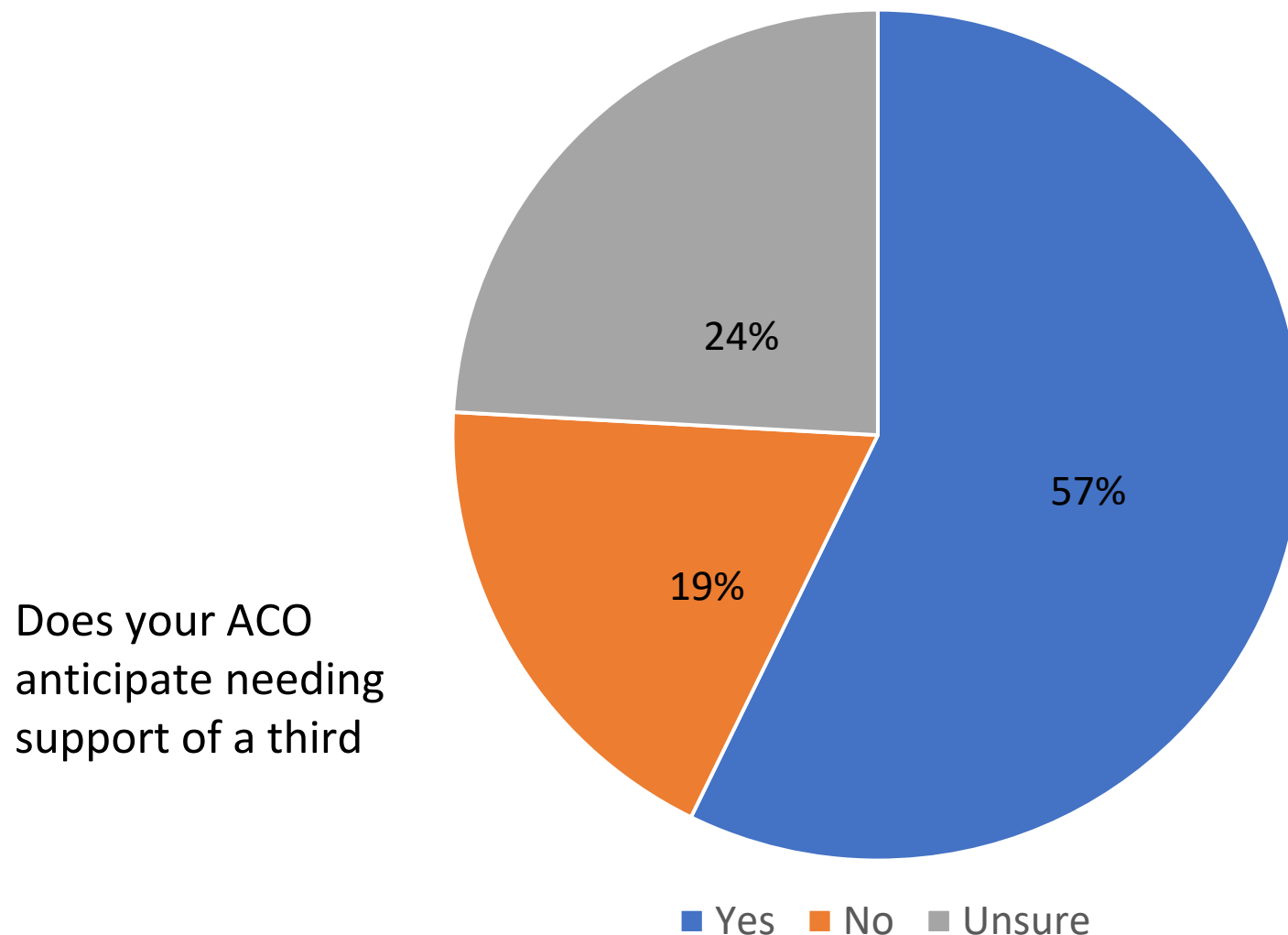
When does your ACO plan to report eCQMs?

■ PY 2022 ■ PY 2023 ■ PY 2024 ■ PY 2025 ■ Not Sure

## Costs, workflow redesigns ranked as top concerns

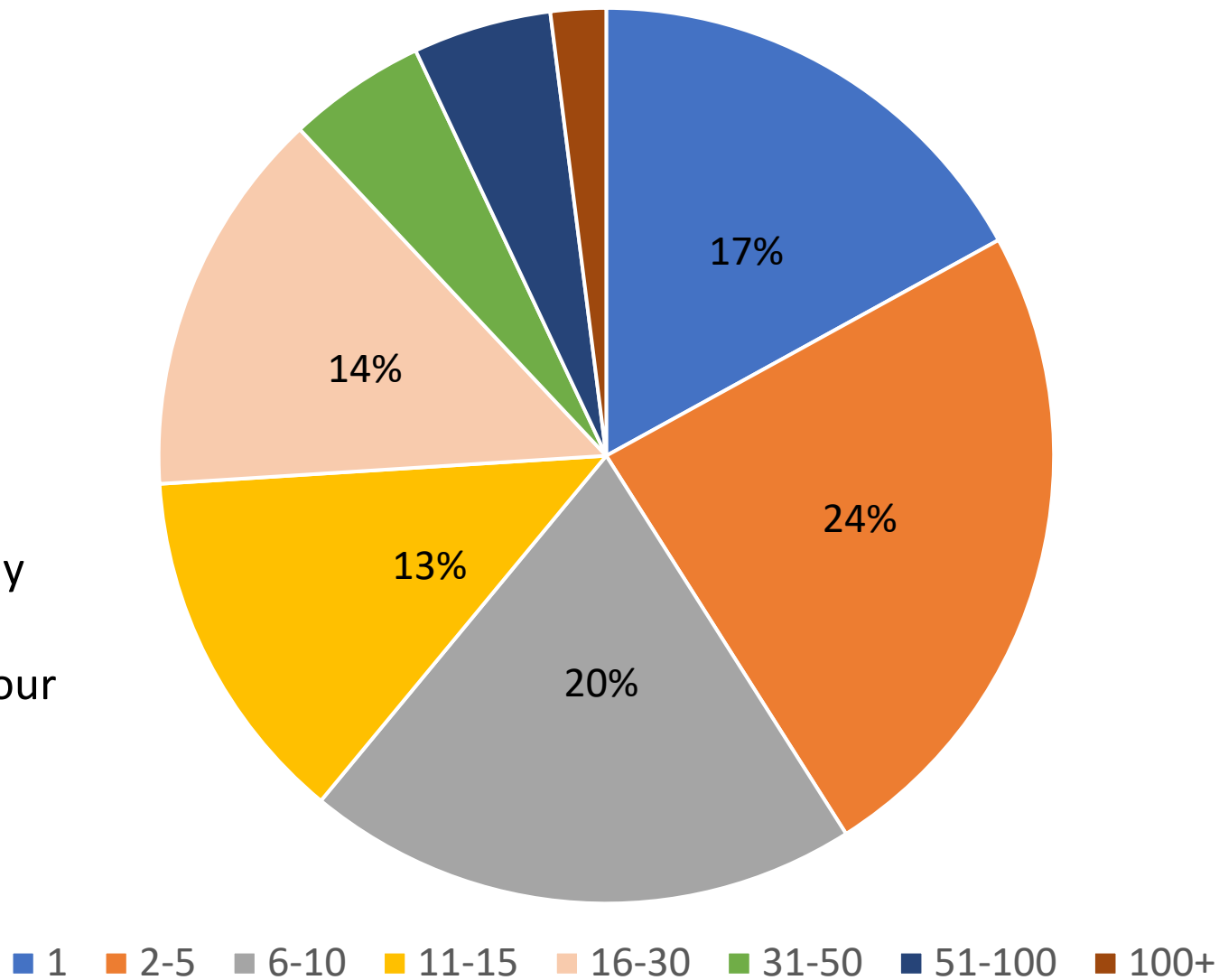


## 57% anticipate needing the support of a third party data aggregator (who is not the EHR vendor)



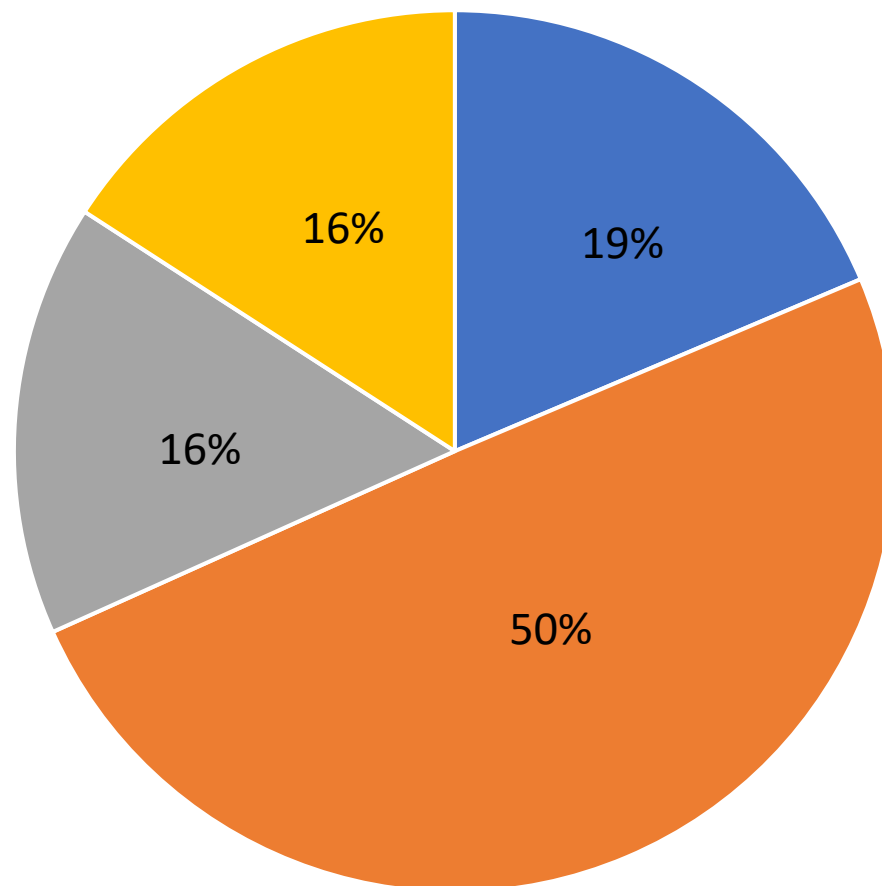
## Only 17% of respondents have one EMR

How many EMRs are used in your ACO?



**50% of respondents estimate a cost of \$100,000-\$500,000 to implement eCQMs/MIPS CQMs for the 1<sup>st</sup> year of reporting**

What is your best estimate for total costs to meet eCQM/MIPS CQM req's for the first year of reporting?



■ \$0-\$99,999   ■ \$100,000-\$499,999   ■ \$500,000-\$999,999   ■ \$1,000,000+

# Key Issues



# Key Issues.....



- 1. Data Standards and Interoperability:** The current state of data standards and interoperability will not yet fully enable ACOs to meet the eCQM reporting requirements successfully.
- 2. All Payer Data:** The shift to all payer data has unintended consequences and will result in ACOs being measured not on clinical quality of care provided, but rather the composition of the ACO and the payer mix and comes with significant data extraction costs.
- 3. Patient Matching:** There is a general lack of experience and solutions readily available to address patient matching needs.

# Key Issues.....



- 4. Workflow Changes:** eCQMs may eventually reduce administrative burdens associated with reporting, however they still require significant workflow changes to capture appropriate information in the EHR in the appropriate location. These burdens and costs must be accounted for when developing timelines for changing measure sets and specifications.
- 5. Costs & Admin Burdens:** ACOs face significant costs and administrative burdens to implement changes necessary to report eCQMs and are not being provided with any additional funding to make such changes.
- 6. Data Validity:** ACOs must ensure that the data used for quality measurement are valid and representative of ACO performance using a broader patient population (data completeness requirements). The requirements as outlined in MIPS should be reevaluated for ACOs, as there are different challenges ACOs face when reporting eCQMs.

# Key Issues.....



## **1. The current state of data standards and interoperability do not yet fully enable ACOs to meet eCQM reporting requirements successfully.**

### **Potential solutions:**

- ONC should include requirements in Certified EHR Technology (CEHRT) criteria for vendors to better support ACOs in this work. This includes additional capabilities and support around data/value set mapping as well as collection of QRDA I files to better support patient matching and provide capabilities for accurate patient matching.
- It is critical that underlying certification criteria support ACOs in what they are required by CMS to achieve for eCQM or dQM reporting.
- Please see appendix for additional technical recommendations

# Key Issues.....



- 2. The shift to all payer data has unintended consequences and will result in ACOs being measured not on clinical quality of care provided, but rather the composition of the ACO and the payer mix. It also will result in significant data extraction costs for ACOs.**

## **Potential solutions:**

- Consider alternatives such as relying on all attributed ACO patients;
- CMS should not tie this data to shared savings.

# Key Issues.....



## **3. There is a general lack of experience and solutions readily available to address patient matching needs absent a national patient identifier.**

### **Potential solutions:**

- Consider revisions to QRDA I, such as adding more demographic fields, or finding an alternative pathway by which data can be transmitted in a standardized way to enable successful patient matching (or use a national patient identifier);
- Develop additional guidance regarding how CMS expects patient matching to be completed and what the rate of accuracy in patient matching is expected to be, knowing there will never be 100 percent accuracy without a national patient identifier.

# Key Issues.....



## **4. eCQMs still require workflow changes, and therefore clinician behavior changes, to capture the appropriate information in the EHR in the appropriate location.**

### **Key concerns:**

- CMS must recognize these burdens as it considers changes to measure sets and must work to create stability in the programs to minimize the need for constant changes;
- The industry needs more standardization and assistance for ACOs with code capture to eliminate the workflow changes that are required;
- CMS must prioritize alignment of measure specifications across quality programs and with private payers to eliminate differences in measure requirements and reduce the burden of data collection.

# Key Issues.....



## **5. ACOs face significant costs and administrative burdens to implement these changes.**

### **Potential solutions:**

- CMS should consider providing grant funding to ACOs to help offset initial and ongoing costs;
- CMS should consider providing certain policy incentives to help offset these costs such as making measures pay-for-reporting if reported via eCQM, ensuring shared savings are not at risk, or providing alternative financial benchmark policies to ACOs reporting eCQMs.

# Key Issues



- 6. ACOs must ensure that the data used for quality measurement are valid and representative of ACO performance using a broader patient population (data completeness criteria). These data completeness requirements were created for MIPS, which requires aggregation and analysis for ACOs from a broader set of patients and practices than previously encountered by other MIPS participants.**

## **Potential solutions:**

- CMS should consider alternative data completeness standards for ACOs or remove this requirement altogether;
- CMS should consider allowing for exceptions/exclusions for certain practices within the ACO (like small practices);
- CMS could consider removing data completeness requirements for ACOs until or unless the validation process becomes more automated.

# Appendix



# Requisite EMR Vendor Capabilities

Capability	Details	Scope of Requirement
<b>Produce eQMs</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> View eQm performance in easily accessed dashboard</li> <li><input type="checkbox"/> Tool to drilldown to patient level to understand and validate outcome calculation</li> <li><input type="checkbox"/> Generate QRDA 1 and QRDA 3 files for <u>all</u> requisite MIPS eQMs</li> <li><input type="checkbox"/> Complete data/value set mapping within EMR</li> <li><input type="checkbox"/> Create utility to identify gaps in mapping</li> <li><input type="checkbox"/> Enable practice customization to account for unique workflows</li> <li><input type="checkbox"/> Update measure specifications to reflect annual rulemaking. Changes should be made available via software updates for health systems/practices on earlier versions of the EMR. Development timeframe and implementation estimates should be publicly posted.</li> </ul>	ALL vendors – Part of CEHRT
<b>Transfer of eQMs between disparate EMRs</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Facilitate secure exchange of eQm QRDA 1 files from one EMR to another (<i>likely only feasible with corresponding ONC policy</i>)</li> <li><input type="checkbox"/> Ensure ingestion of QRDA 1 files into “base EMR” does not compromise patient data or negatively impact system performance</li> <li><input type="checkbox"/> Additional requirements exist if disparate EMRs utilize FHIR to facilitate exchange</li> </ul>	Any EMR vendor that seeks demarcation as “ACO reporting compliant” (or something like that)
<b>Aggregation &amp; Deduplication</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Must facilitate/accommodate patient matching (&lt;10%)</li> <li><input type="checkbox"/> Ability to remove duplicate patients per measure specifications</li> <li><input type="checkbox"/> Construct ACO-level summary</li> </ul>	

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<b>Transfer of eQMs between disparate EMRs</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Facilitate secure exchange of data underlying eQMs/dQMs from one EMR to another (<i>likely only feasible with corresponding ONC policy</i>)</li> <li><input type="checkbox"/> Enable mapping requisite for utilization of FHIR (help automatic transfer of mapping completed for eQMs to future state FHIR)</li> </ul>	
<b>Aggregation &amp; Deduplication</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Ensure ingestion of eQm data into “base EMR” does not compromise patient data or negatively impact system performance</li> <li><input type="checkbox"/> Must facilitate/accommodate patient matching (&lt;10% error rate)</li> <li><input type="checkbox"/> Ability to remove duplicate patients per measure specifications</li> <li><input type="checkbox"/> Construct ACO-level summary</li> </ul>	Any EMR vendor that seeks demarcation as “ACO reporting compliant” (or something like that)