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How ACOs should prepare for the 2025 requirements around **quality reporting**

Effective compliance with CMS's new digital approach to reporting quality performance is imperative for accountable care organizations (ACOs) to reap the full financial rewards of participating in the Medicare Shared Savings Program (MSSP).

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This year, MSSP ACOs face increased pressure to enhance care quality and manage costs with the transition from manual to electronic clinical quality measures (eCQMs) and the MSSP's intensified compliance requirements.

This shift to electronic reporting is a financially driven transformation. The reporting complexity has increased significantly as ACOs are now required to report on their entire patient population, representing a dramatic expansion of reporting applications from about 3,300 patients under the CMS web interface to potentially over 2 million for large health systems, such as Northwell Health in New Hyde Park, N.Y., whose experiences and lessons learned from meeting these intensified requirements are described later in this article.

NEW REPORTING REQUIREMENTS BRING INCREASED COMPLEXITY

The changes, outlined in the CY2025 Medicare Physician Fee Schedule final rule, require ACOs to update and strengthen their strategies focused on ensuring compliance, high-quality patient outcomes and financial sustainability.

The MSSP has long rewarded ACOs that achieve high-quality care and reduce unnecessary costs, thereby aligning financial incentives with quality improvement. The new reporting

requirements mark a major shift, however, from the CMS web interface, where reporting covered a sample of Medicare beneficiaries, allowing ACOs to abstract charts manually. Its low cost and simplicity made it popular. The increased operational complexity of eCQMs makes reporting more difficult and increases the burden on clinician and practice engagement.

Until this year, the CMS web interface remained the primary method of submission; only 16% of eligible MSSP ACOs used eCQMs/CQMs in 2023.[a] Now, 100% compliance is required.

Under the previous method, reporting was limited mostly to primary care physicians, whose efforts could be captured entirely through a careful review of documentation. With the new method, reporting requirements are expanded to include specialists, and the clinicians must follow often cumbersome electronic workflows to document their efforts in discrete data fields, thereby increasing the burden with each clinical visit for the physician and the team.

An ACO that does not submit eCQMs/CQMs in 2025 will not have its performance scored for quality, in effect scoring a zero. The ACO would not only be barred from participating in any shared savings opportunities but also would likely be placed under review by CMS. The ACO's physicians and tax-identification numbers (TINs) that lean on their ACO submission also would fail to meet their Merit-Based Incentive Payment System (MIPS) reporting requirements. The MIPS program has implications for Medicare Part B payment adjustments as low as −9.0% for low performance, which can have a massive financial impact on an organization.

a. CMS.gov, "Performance year financial and quality results," Medicare Shared Savings Program, Oct. 29, 2024.

NEXT PAGE

Financial and cultural consequences of the new quality reporting requirements for ACOs

The financial burden of the complexity inherent in CMS's intensified quality reporting requirements for ACOs participating in the Medicare Shared Savings Program is threefold:

1. The cost of infrastructure upgrades such as integrating data sources across multiple electronic health records (EHRs)
2. Ongoing operational costs related to data management, staff training and quality improvement
3. Training and operationalization of digital workflows, including the potential need for EHR customizations, additional clinical training and data validation.

To avoid financial penalties and achieve shared savings, ACOs must invest early in both the tools and the training that are needed to ensure compliance with the new reporting standards.

The transition to population-level reporting also marks a significant departure from the traditional reporting approach, which focused on a sample of Medicare beneficiaries. This shift presents both opportunities and challenges for ACOs.

On one hand, population-level reporting allows ACOs to take a more comprehensive approach to quality improvement by focusing on the entire patient population. It therefore aligns with the broader healthcare goals of improving health and reducing healthcare disparities.

On the other hand, ACOs face the challenge of having to ensure their data systems can handle the volume and complexity of population-level reporting. This may involve upgrading existing EHR systems, developing new data integration tools and implementing dashboards that allow for real-time monitoring of quality performance.

Another challenge is the ACO composition. The clinical quality measures impacted are traditionally seen as primary care measures. Expansion to population level means the activation of specialists who have traditionally been less involved in value-based care. Dermatologists, for example, will be expected to screen for depression.

Comparison of electronic clinical quality measures (eCQMs) and Medicare CQMs

Category	eCQM	Medicare CQM
Population	Focused on all eligible patients based on measure specification	Focused on Medicare beneficiaries who are eligible based on measure specification (subset of Medicare Part B patients)
Certified electronic health record (EHR) technology (CEHRT) status	All EHRs must be on latest CEHRT standards	EHRs do not need to meet CEHRT requirements
Data sources	Limited to QRDA-I (patient level) and QRDA-III (aggregated for submission) only*	Expanded data collection options (extracts, QRDA-I, reports) including manual chart abstraction and claims data*
Data completeness	Meets data completeness requirements if aggregation occurs within an EHR environment	Higher level of scrutiny due to data completeness requirements

* QRDA = quality reporting document architecture
Source: CMS, "Updated eCQM specifications and implementation resources for 2025 performance/reporting period," May 3, 2024

THE NEED FOR DATA AGGREGATION BRINGS FURTHER CHALLENGES

Data aggregation is crucial for eCQMs. It involves combining data from diverse sources, often including multiple EHRs, which increases the challenges it poses. A 2022 survey by the National Association of ACOs (NAACOS) revealed more than three-fourths of ACOs have at least six EHRs.[b] The ACO will incur costs whether it uses a third-party vendor or an in-house data warehouse.

The complexity necessitates an early start. Ideally, ACOs should have used the now-past transition period to map out the data aggregation process, including reviewing their EHR workflows to verify they have successfully adopted the new approach. For example, conducting depression screening using paper forms scanned into the medical record will not achieve performance points if there is not a prescribed electronic workflow.

b. Hagland, M., "NAACOS convenes task force on digital quality measurement," *Healthcare Innovation,* April 12, 2022.

Each ACO also must ensure it has the proper infrastructure to support the aggregation efforts, and it must develop an enterprise master patient index (EMPI) to ensure that each patient has a unique identifier assigned to support ongoing validation efforts.

Ultimately, ACOs are expected to aggregate data across all participating TINs and to provide data from every electronic health record (EHR) in the ACO. The best place to start is with a needs assessment.

HOW TO PERFORM THE NEEDS ASSESSMENT

The needs assessment analysis breaks down specific requirements in three areas to help define the project's overall scope.

1 Data sources. The ACO should identify which systems are relevant for data collection, including the EHRs and billing systems. Each system should be assessed for its ability to produce data extracts, what data points can be made available in the extracts, potential fees or costs and frequency. A full operational assessment of current workflows should be performed, with the following steps:

- A review of measure requirements, including deconstructing measures to ensure each key data element can be linked back to a data source, performed by a multidisciplinary team of IT, analytics, EHR, quality and clinical team members
- For each EHR, verification of the certified EHR technology (CEHRT) status and the ability to use Quality Reporting Document Architecture (QRDA) to produce QRDA-I files and custom extracts in a CSV (comma-separated value) format
- Verification that every TIN and EHR is represented in the process

2 Eligible patients. By determining which systems are the primary data drivers, the ACO can prioritize systems that account for most of its data, which will enable it to approximate the measure denominator (i.e., number of eligible

patients) and, thereby, identify the number of providers who need to be engaged in performance improvement initiatives.

3 **Performance.** The ACO can use the approximated denominator to conduct a preliminary performance review, comparing current performance against the preliminary estimate to identify gaps. By collecting additional elements such as specialty and location, the ACO can gain deeper insight into performance, including the existence of performance gaps by specialty and whether performance is low for specific population segments.

Performance data is essential for setting realistic expectations. The changes represent a cultural shift (as is discussed in the sidebar on page 2), particularly for specialists less accustomed to value-based care who may resist the changes if they are not implemented properly. A key purpose of the needs assessment, therefore, is to help ensure the most-effective submission method possible by assessing the ACO's readiness for each reporting method.

For eCQMs, ACOs must aggregate data collected from each EHR and TIN for every required measure using QRDA files, which rely on CEHRT. However, several challenges exist:

Although many EHRs meet the CEHRT requirement, many practices lack the technical expertise to work with these files, placing a significant burden on IT teams to manage systems and maintain vendor relationships.

Some EHR vendors charge fees for generating QRDA-I files, which can quickly escalate for organizations with numerous EHRs.

To aggregate the QRDA-I files into a qualified registry or EHR for deduplication and patient matching, as required, the ACO must adhere to strict standards to ensure all necessary patient data is captured accurately.

CMS may also request technical documentation and internal organizational policies that document the ACO's approach to patient matching and deduplication to ensure it meets the "true, accurate, and complete" requirements of the Federal Code of Regulations (§414.1340, "Data completeness criteria for the quality performance category").

Therefore, it is critical that the data aggregation process include a multidisciplinary team represented by the areas of IT, quality, ACO governance, risk management and legal. The documentation will need to be updated periodically as the process inputs evolve.

Because of the process's complexity, some ACOs have pursued an alternative reporting option, including possible removal of TINs that are unable to produce the required QRDA-I files. To remediate this option, CMS provides a more flexible collection process through the Medicare CQM reporting option, which follows the MIPS

NEXT PAGE

Key points to consider when determining whether to buy or build

The decision to buy or build a data collection and reporting system is a fundamental consideration for an accountable care organization (ACO) when performing a needs assessment to prepare for compliance with CMS's new electronic quality reporting requirements. The question is whether to partner with a third-party or to develop in-house solutions to streamline data collection and reporting. CMS provides an annually updated list of approved qualified registries in the Quality Payment Program (QPP) Resource Library. When selecting a vendor, prioritize flexibility in supporting both eCQMs and CQMs, and evaluate their specialties, experience and compliance history. To ensure fairness, establish a request-for-proposal (RFP) process with a scoring rubric.

The RFP process should address key domains associated with regulatory, architecture, data analytics and integrations. Each domain should include prioritized questions distinguishing must-have functionality or features versus those that are "nice to have." Each vendor should also complete an organization's IT risk and compliance review, provide at least two client references and host demonstrations of the product. Lastly, an estimated total cost should be provided. The estimated total cost should include the total one-time costs regardless of when they occur, and total annual ongoing costs, in a steady state. i.e., when all proposed applications are live in all proposed practices. It should also include all maintenance and support costs and predictable pricing for additional ACO growth.

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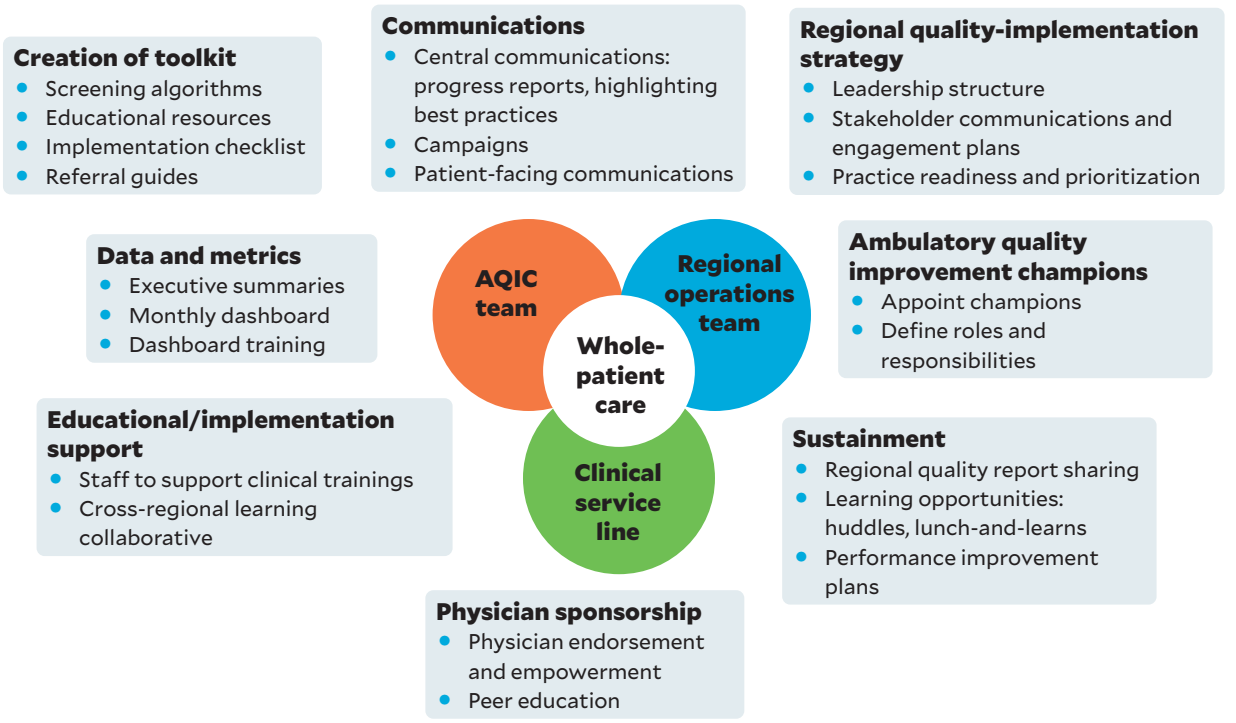
Northwell Health ACO quality reporting implementation and sustainment structure



Source: Northwell Health, 2024

CQM requirement but limits the reporting population to fee-for-service beneficiaries identified through quarterly files. The exhibit on page 3 summarizes the differences between reporting options.

CMS also offers bonus incentives for reporting eCQM through complex organizational adjustment (proposed for 2025) and a lower quality performance standard for shared savings eligibility. CMS noted in the 2025 Final Rule that MIPS CQMs will be available only through the 2026 performance year.

LESSONS LEARNED FROM NORTHWELL HEALTH'S EXPERIENCE

To prepare for the new reporting requirements, White Plains, N.Y.-based Northwell Health developed an improvement structure focused on the partnership among the ambulatory quality improvement collaborative (AQIC) team, regional operations and clinical service-line leaders. The partnership was crucial to implementing and sustaining needed changes. Primary responsibilities of each group are outlined in the exhibit above. These groups work together under the direction of a combined workgroup that meets monthly.

Northwell learned four important lessons from this experience.

1 Monitor performance in real time, where possible. Data aggregation across a myriad of systems includes the time lag from collecting and aggregation, resulting in outdated performance data. ACOs should, where possible, develop real-time performance-tracking tools

so providers can monitor their metrics. An end-of-year scramble is ineffective since reporting spans the entire calendar year, and the denominator will be too large to influence if addressed too late. Performance tracking tools allow the care team to partake in the performance improvement process and take charge of change locally.

2 Foster stakeholder engagement and collaboration. From its experience with its ACO transition, Northwell Health found that stakeholder engagement was essential. Successful implementation requires buy-in from a wide range of stakeholders, including physicians, nurses, operational leaders and IT staff. By involving these stakeholders in the planning and execution of quality improvement initiatives, ACOs can ensure that everyone is aligned with the organization's goals and committed to achieving success.

3 Engage data infrastructure and technical experts. Another critical element was having a robust data strategy and technical expertise. ACOs require the right analytics and quality-reporting tools and systems to aggregate and report data accurately, obtainable either through partnering with third-party vendors or developing in-house expertise. ACOs also must invest in ongoing training and support to ensure they understand how to use the new data systems and workflows. This education should include a focus on the importance of quality reporting and how it impacts the organization's financial performance.

4 Expect the unexpected. The more complex an organization and its data structures are, the greater the likelihood that it will encounter delays and unexpected issues that can affect timelines. The ability to remain agile is crucial.

Leaders should embrace the maxim "Do not let perfection be the enemy of excellence." Using an iterative process for improvement will give the team a sense of steadily making progress and afford an opportunity to begin using directional data for specific improvement initiatives.

The financial imperative is clear: ACOs must optimize performance to secure shared savings and avoid penalties in MIPS.

For example, collecting data from multiple systems will take time. Instead of waiting for data from all systems, ACOs should start improvement initiatives once they have at least some data, with an eye to making more improvements over time. The data collected during this process will directionally inform the ACO of its progress, allowing for more adjustments to be made as data is added.

IMMEDIATE ACTION IS IMPERATIVE

The 2025 transition to eCQMs/CQMs brings challenges and opportunities for ACOs to embrace changes that can improve patient outcomes and achieve financial success.

The financial imperative is clear: ACOs must optimize performance to secure shared savings and avoid penalties in MIPS. Robust data aggregation and quality improvement processes are essential for accurate reporting and better outcomes, enabling ACOs to navigate MSSP complexities and thrive in 2025 and beyond. ▮

About the authors

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