Initial Observations for M-CQM / eCQM Reporting for ACOs

September 9, 2024

Aledade

Agenda

1. Current Context

2. 2 Learnings and Key Takeaways

Lesson 1:
"Automated CEHRT reporting" can be easy, or very very hard

Lesson 2:
Medicare CQM reporting will drive erroneously low scores

3. Forging the Path Forward

CMS Has Proposed 2 Quality Reporting Options for 2025: eCQMs or M-CQMs

	Web Interface	eCQMs	Medicare CQM (M-CQMs)
2025+ Perf Years	**No Longer Permitted**	Long term destination	Permitted option
Measures	8 Measures	3 Measures(BP/A1c/Depression) **+2 Proposed(CRC / BCS)**	3 Measures(BP/A1c/Depression) **+2 Proposed(CRC / BCS)**
Patients	Sample of 240 MSSP Attributed LUM / Measure	All Patients, All Payers with qualifying encounters	All Traditional Medicare patients with qualifying encounter
Data Sources Allowed	Any (EHRs, HIEs, Labs, Manual)	**Automated CEHRT EHR interfaces only**	Any (EHRs, HIEs, Labs)
Certification Required	CMS Qualified Registry	ONC CEHRT Quality Measure Criteria	CMS Qualified Registry
Performance Required to Retain All Savings	40th Percentile Overall (>77%) (Web Interface Benchmarks)	40th percentile in one measure 10th percentile in another measure	**40th Percentile Overall (>77%)** **(Inherits Web Interface Benchmarks)**
CEHRT Requirements	Promoting Interoperability (75% of Providers)	Promoting Interoperability (75% of Providers) ****Data completeness may force 100%****	Promoting Interoperability (75% of Providers)
Data Completeness Req	100% for Sampled Patients Only	**70% of all Patient Encounters**	70% of all Medicare Patient Encounters

We support the movement towards electronic quality reporting that promotes interoperability and is simpler for practices. Individual practices have successfully reported eCQMs under MIPS.

But this rule, if finalized as proposed would cause serious challenges for multi-practice ACOs

eCQM Feasibility

Lesson One: "Automated CEHRT reporting" can be easy, or very very hard

The reporting process works for individual practices with one EHR where an EHR-calculated (QRDA-III) file outputs quality scores
Under current interpretation, Multi-TIN ACOs must assemble individual patient-level (QRDA-I) files, merge and deduplicate them, and try to calculate a combined quality score across multiple EHRs

One Practice on One EHR

MIPS or ACO reporting as a single TIN

QRDA-III

Sent for reporting! ✔

"Hit a button and you're done!"

Multi-TIN ACOs

On a Variety of EHRs

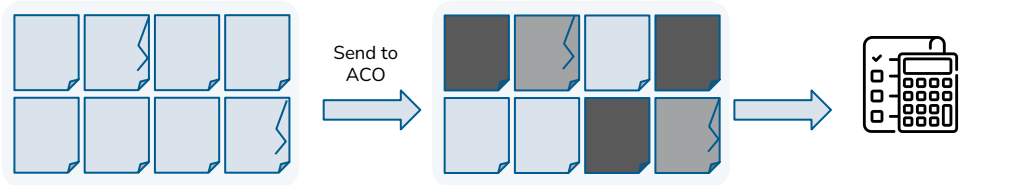
Heart of the problem:

Generating QRDA-I files is the most difficult step, often resulting in roadblocks (e.g. long wait times, lack of data, invalid data) before submission can be attempted.

10%[1] success rate → Within the 10% success rate, **many are broken** or only partially viable. → **Success is not guaranteed** across all quality measures, and may be isolated to one or two from the required list.

De-Duplication and Score Calculation

Even if some files are successful or close to successful, there is the additional hurdle of interpreting the data in files for de-duplication, exceptions, exclusions, and score calculation:



QRDA-I Creation
Patient Level Files; some are broken or not viable.

De-Duplication, Exceptions, Exclusions
A small % of LUM sees duplication.

Score Calculation
For each mandated quality measure

[1]Across 10 of the top CEHRT vendors at Aledade. A full list of the CEHRTs and success levels will be shown on the proceeding slides.

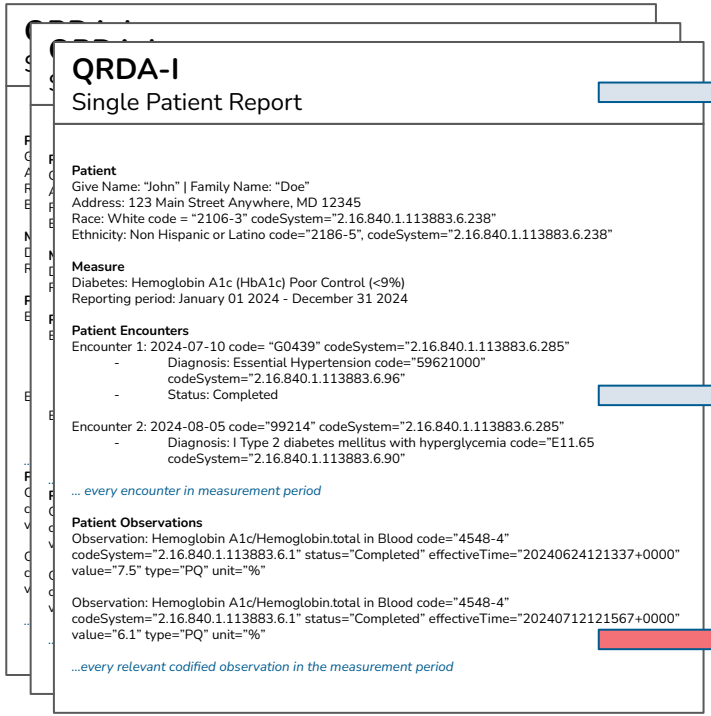
QRDA-IIIs provide clear quality reporting and require less to prepare and understand.

QRDA-IIIs are simpler to understand and better accomplish the end goal of clearly and accurately reporting quality outcomes.

QRDA-III
Reporting Period January 1, 2024 - December 31 2024

Measure: Controlling High Blood Pressure	
Initial Population	1000
Denominator Exclusions	50
Denominator	950
Numerator	800
Measure: A1c Poor Control	
Initial Population	950
Denominator Exclusions	0
Denominator	950
Numerator	100

Easy to read and concise



Difficult to read or audit and very large
(~2,000-15,000 lines of code per patient, per measure)

Thousands of files per EHR are required

Details each encounter, diagnosis, observation, provider, etc.

Largely extraneous detail beyond what is necessary for quality reporting.

QRDA-I reporting is incomplete and unsuccessful out of the box.

QRDA-I export has not historically been emphasized and there are significant growing pains during setup.

Lesson 1

CEHRT Vendor	QRDA-III Outcome	QRDA-I Outcome
Greenway Intergy	**Successful**	**Successful**
AdvancedMd	**Successful**	**Unsuccessful** *Invalid Codes throughout the document*
AthenaClinicals	**Successful**	**Partially Successful** Requires over 1-2 weeks to extract
Azalea EHR	**Successful**	**Partially Successful** BP passed, A1C did not pass
Epic	**Successful**	**Functionality Unknown** Outreach has been attempted, with long wait times.
Practice Fusion	**Successful**	**Unsuccessful** Retired data sources with invalid outputs
Nextgen Office	**Successful**	**Unsuccessful** Ineligible Data
eClinicalWorks ($350 / NPI / Year)	**Successful**	**Unsuccessful** 48 hours per extract, invalid data
PrognoCIS EHR by Bizmatics	**Functionality Unknown**	**Unsuccessful** Invalid documentation

EHR Vendors have prioritized internal quality reporting capabilities vs export capabilities

- QRDA-III reporting has shown across-the-board success in retrieving valid format and content for Blood Pressure, A1C, and Depression Screening reports for CEHRT vendors where extracts were attempted.
- QRDA-I reporting outcomes are largely unsuccessful, with long wait times and regularly invalid data.

QRDA-I pathway requires significant additional staffing and costs for multi-TIN ACOs

Even with these investments, there's no guarantee of meeting "70% of all patient encounters" completeness requirement

"Best case" scenario for ACO Resourcing

- ACOs that have not engaged in quality reporting would need several new team members, including integration engineers, project managers, EHR specialists & quality reporting specialists to support this work. Finding these skilled technology workers can be challenging, particularly for underserved communities
- There are additional costs, even at scale, including practice workflow changes and operational barriers that prevent quick pivoting based on reporting requirements.
- Aledade's operational expenses are lower due to economies of scale. Greater sophistication via our engineering and product teams means that **this is a "best case," rather than the status quo** for independent providers.

Minimum Additional Expenses[1]	Support Type	Per ACO	Illustrative Example
Additional Staffing/Contracting	EHR Optimization	$38K	QRDA extract & EHR optimization support: 16hrs / prac @ $58/hr Interface Consulting: 20hrs / prac @ $72/hr
	Product / Eng OpEx	$74k	½ technical FTE / ACO
Data Extraction	CEHRT/QRDA Enablement Fees	$74k	eCW: $350 / NPI / yr Veradigm Pro: $768 / NPI / yr
Registry Vendor		$19k	$1,370 / ACO / month + hourly professional services

[1]*Based on internal budget projections and vendor contracts for 2024*

QRDA-III is a More Proven and Reliable Solution than QRDA-I.

If we are routinely running into issues with QRDA-I's, how have has MIPS eCQM reporting been so successful? Both QRDA-III and QRDA-I are only used for quality reporting and everyone uses QRDA-III.

QRDA-III (Group Level)

- ✔ **Higher market demand**[1] Primary mechanism to report MIPS eCQMs at individual NPI or group TIN level.
- ✔ **Less computationally expensive** to generate. One document per report.
- ✔ **Lower complexity** and less detailed dataset to export, requiring less configuration and EHR mapping

QRDA-I (Patient Level)

- ✘ **Lower market demand**[1]. Only required for APMs reporting across multiple EHRs.
- ✘ **More computationally expensive**. Tens of thousands of documents generated for each measure.
- ✘ **Higher complexity**, requiring extensive configuration and detailed data mappings for an export.

Potential Solution Allow ACOs to use a weighted average of the QRDA-III from practices.[2]

[1] 75.9% MIPS eligible clinicians reported at Individual or Group (TIN) level (2022 QPP Experience Report). While 24.1% participated and reported as an APM entity, many of these report from a single EHR instance and never require QRDA-I data.

[2] CMS considered this in the past and went the QRDA-I route out of concerns around duplication of patients across practices. We believe CMS should reconsider those concerns and issue subregulatory guidance to allow this process. The vast expense and immaturity of QRDA-Is is far more cost than any benefit of de-duplicated patients. QRDA-I are not used by anyone, anywhere for the exchange of clinical data.

M-CQM Feasibility

What about M-CQMs?

- In addition to a more limited population (identified Medicare patients), M-CQMs permit use of electronic data from multiple sources, and in multiple formats
- ACOs can access, report, and improve quality by using clinical data from:
  - Proprietary EHR Interfaces, CCDAs
  - FHIR Interfaces
  - Health information exchanges, QHINs/ TEFCA
  - Direct lab feeds
  - Other electronic means
- Web Interface reporting has benefitted from these electronic data but achieving reliable quality reporting has still required manual chart reviews on a significant portion of sampled patients.

Clinical measures have moderate to low yields with current solutions.

1,690
MSSP Practices with >160 EHRs

93%
1,563 Practices with Clinical Integrations[1]

Clinical Observations	Observation Capture Rate
Blood Pressure Observations	**70%**
A1cs	**64%**
PHQ2/PHQ9 *Depression Screenings*	**24%**
Mammograms	**32%**
Colonoscopies	**33%**

Aledade invests significant technical resources in data interoperability and still faces daily challenges in data completeness

Common challenges include:

- Health systems often take **years to resource an integration** for dependent practices
- Data transmission outside the context of the encounter
- **Structured data capture doesn't always translate** to structured data in C-CDAs

Challenges will be worse for eCQM and M-CQM

- No ability to filter to minimum necessary patients; eCQM & M-CQM are much broader in scope.

[1] *Clinical Integrations include C-CDA, Database Extracts, APIs, and Lab Vendors*

Accessing Interfaces is difficult across EHRs.

Primary Barrier	Vendor	Impact
Health System Engagement	Epic Hosting Entity	22/123 (18%) Practices w No Interface Median 243 days to go-live
	MEDITECH Hosting Entity	6/11 (55%) Practices w No Interface Median 739 days to go-live
	Cerner Hosting Entity	4/14 (29%) Practices w No Interface Median 475 days to go-live
Technical Capability	PracticeFusion	71 Practices w Manual C-CDA Only
Cost	eClinicalWorks	20/410 (5%) w No Interface
All Others	-	57/1059 (5%) w No Interface Typically due to pending EHR transitions impacting integration timelines

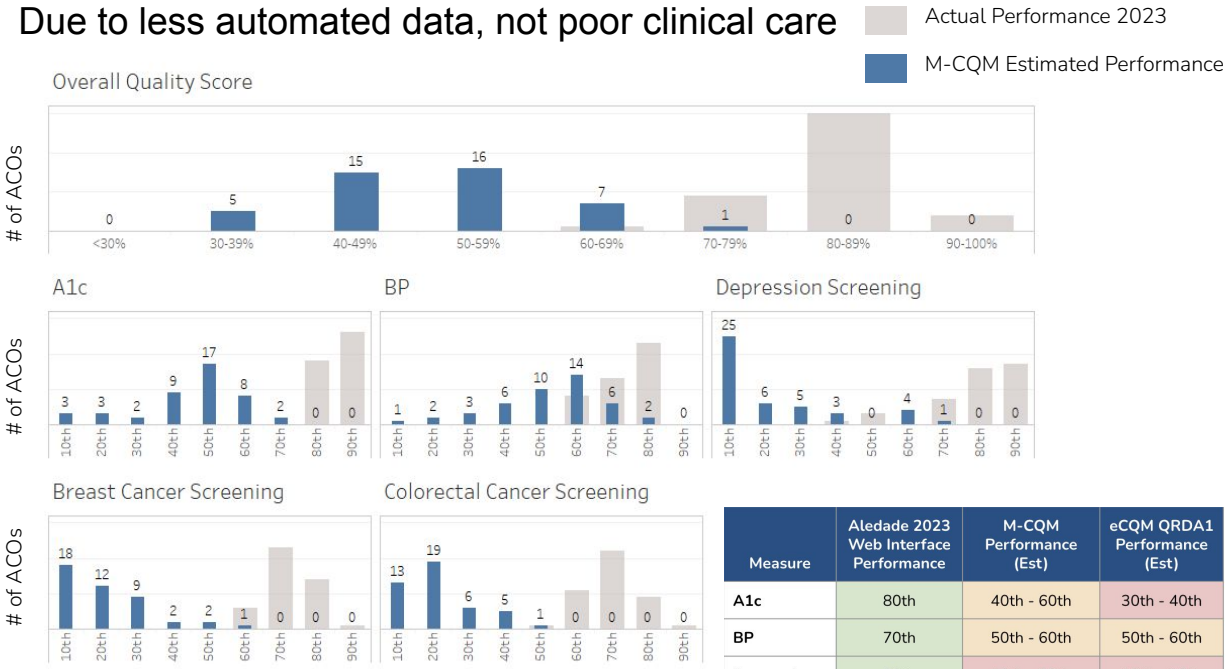
Barriers to ongoing clinical integration

- Health system willingness to engage in integrations or support them in a timely manner remains primary barrier for practices whose EHR is hosted by the health system.
- Some platforms lack proven integration capabilities to support ongoing automated clinical integration.
- Vendors like eCW who have a per-provider fee present significant cost barriers to CHCs with a large provider panel but a relatively low medicare patient panel.

Link to list of practices without clinical interface Live

Lesson 2: Transition to Electronic Quality Reporting Will Drive Erroneously Low Scores

Due to less automated data, not poor clinical care



Measure	Aledade 2023 Web Interface Performance	M-CQM Performance (Est)	eCQM QRDA1 Performance (Est)
A1c	80th	40th - 60th	30th - 40th
BP	70th	50th - 60th	50th - 60th
Depression	80th	10th - 30th	10th - 30th
BCS	70th	10th - 30th	10th - 20th
CRC	70th	20th - 30th	10th - 20th

Applies ACO-specific data completeness to PY23 Web Interface performance to estimate mCQM performance. Carries forward PY23 Utilization and CAHPS scores.

"Filling in the gaps" manually through chart reviews is feasible when applied to a sample of eligible patients through web interface reporting, but would be infeasible/ prohibitively expensive for the entire census of Medicare patients

In Medicare-CQMs, multi-practice ACO performance is compared to practices that are **scored on only their best performing measures in MIPS.**

Low-revenue ACOs are disadvantaged compared to high-revenue ACOs.

Independent PCPs are more successful in MSSP, but face a greater burden compared to their health system peers. Meeting reporting requirements can be even more difficult given reduced resourcing.

Function	Low-revenue ACO	High-revenue ACO
Configuring EHRs	✘ *Technical configuration of EHRs more challenging due to less capable EHRs and lack of dedicated IT staff*	✔ Have dedicated IT staff and clinical informaticists
HIE Connection	✘ *Are less connected to HIEs and other data sharing networks*	✔ More likely to have state HIE, Commonwell, Carequality or eHealthExchange connection
External Documentation Access	✘ *Labs and Procedure result routing can fail and unstructured results are common. Additionally, they do not benefit from integrated labs on the same EHR.*	✔ Most referrals are made within the system with structured results routing
Electronic Patient Questionnaire Capabilities	✘ *PHQ2/9 often administered via paper workflows*	✔ *Well configured patient portals, tablets for patient forms, and NLP/dedicated staff support form processing.*

Forging the Path Forward

There are four potential paths for policy intervention, with small details playing a large role.

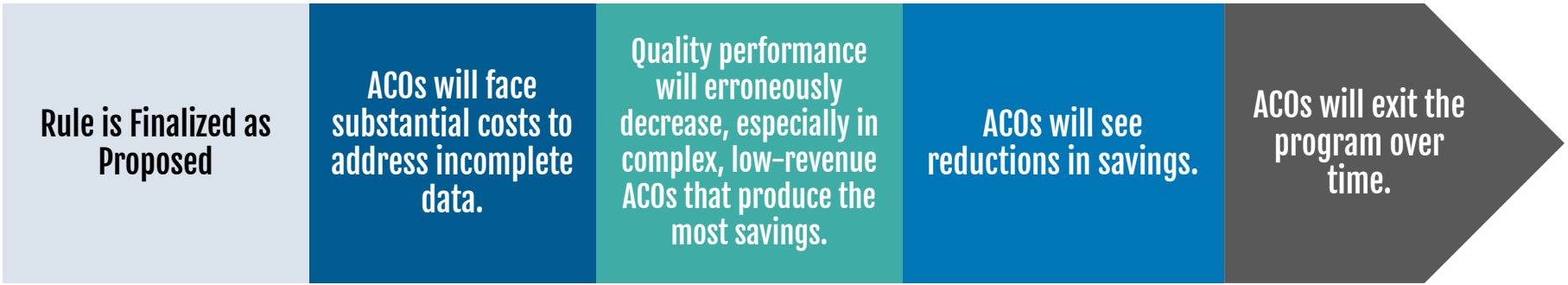
Technical details have major impact the feasibility of M-CQMs and eCQMs

For low-revenue ACOs, **current policies will make M-CQM *performance* near impossible** to achieve and **compliant eCQM submission difficult** to achieve.

Which policy adjustments can ease the transition, encourage ACO participation, and chart a course to eCQMs?

1. **Delay Sunset of Web Interface**
   - *Delaying CQM requirements allow for enforcement of CEHRT requirements, smoother transition for primary care physicians.*
2. **Improve M-CQM Viability**
   - *Reduce the overall quality score cut point in 2025 to account for reduced performance in EHR measures, when compared to Web Interface, due to data automation barriers.*
   - *Delay CRC and BCS measures until 2026+*
3. **Improve e-CQM Viability**
   - *Allow QRDA-IIIs to be used in multi-group ACOs.*
   - *Exclude practices where CEHRT fails to produce a QRDA-I or QRDA-III that passes validation **or***
   - *Reduce data completeness requirements for eCQMs in 2025 to 50%.*
4. **Finalized as Proposed**
   - Finalizing as proposed will have implications and consequences as discussed on next slide.

If the rule is finalized as proposed, the broader MSSP program will face challenges.



The various policy interventions proposed have the ability to alter the course of the MSSP program.

The **current state rule proposal would damage the broader program's viability**, particularly for smaller, more complex, and low-revenue ACOs.