Medicare Shared Savings Program

Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Performance Pathway (APP)

Guidance

MEDICARE SHARED SAVINGS PROGRAM

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1. Overview

According to requirements established within the Calendar Year (CY) 2021 Physician Fee Schedule Final Rule, Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) now report quality performance via the APM Performance Pathway (APP) measure set, which includes an option to continue submitting 10 measures via the Centers for Medicare & Medicaid Services (CMS) Web Interface as in prior years or to submit 3 measures via either the MIPS CQM collection type or the eCQM collection types.[1] In the CY 2022 Physician Fee Schedule Final Rule, CMS finalized policies regarding the sunset of the CMS Web Interface as a collection and submission type under the Merit-based Incentive Payment System (MIPS).[2] The 2024 performance period will be the last performance year that Shared Savings Program ACOs reporting the APP can report quality data through the CMS Web Interface. Beginning with the 2025 performance year, Shared Savings Program ACOs must report quality measures via the MIPS Clinical Quality Measure (CQM) collection type or the electronic Clinical Quality Measure (eCQM) collection type.

ACOs have encountered challenges with aggregating, deduplicating and matching all patient data required under the eCQM and MIPS CQM quality measure collection types given their multiple practices and electronic health records systems. This document describes eCQM and MIPS CQM reporting scenarios specific to Shared Savings Program ACOs and provides guidance on patient matching and data aggregation, and how MIPS data completeness applies to an ACOs eligible and matched patient population.

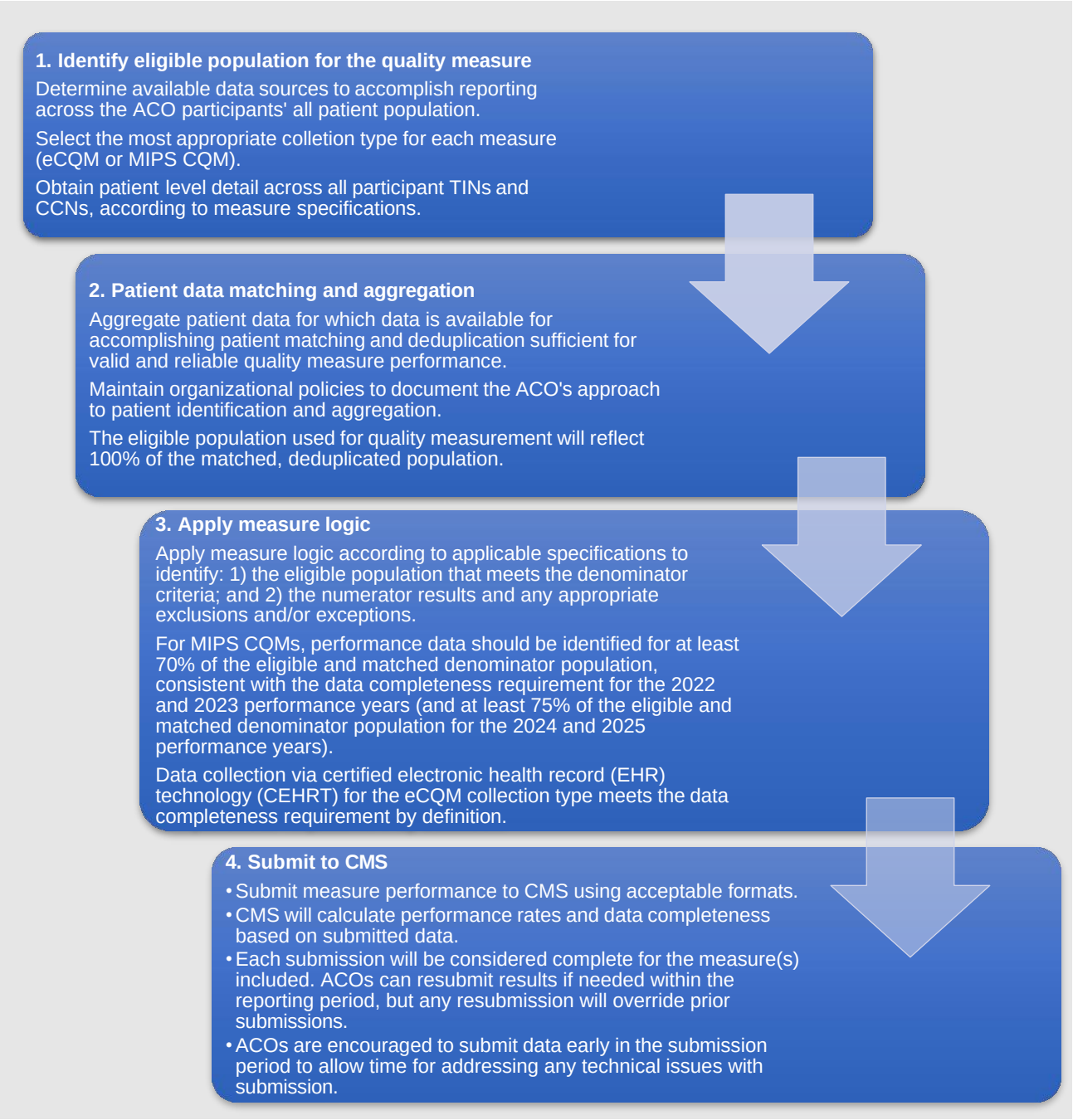
Quality Reporting Process

The specifications and guidance available in support of quality reporting via eCQM and MIPS CQMs provide a framework for ACOs to follow. Within this framework, ACOs can determine how best to gather and report quality performance results according to the structure and needs of each ACO.

Figure 1 provides a high-level overview of the process ACOs may follow to identify the most appropriate data collection type for the ACO's participants, data sources and health information technology resources and successfully complete quality performance reporting.

[1] *See* 42 C.F.R. § 425.512(a)(4).
[2] *See* 42 C.F.R. § 414.1305 (defining “collection type” to include the CMS Web Interface through the CY 2024 performance period for APMs reporting through the APM Performance Pathway).

Figure 1. Quality Reporting Process



2. eCQM and MIPS CQM Collection Types

The 3 MIPS quality measures included in the APP measure set for the eCQM or MIPS CQM collection types are listed in Table 1.

Table 1: APP Measure Set for eCQM or MIPS CQM Reporting

Measure Title	MIPS Quality ID	CMS eCQM ID*
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	001	CMS122v10
Controlling High Blood Pressure	236	CMS165v10
Preventative Care and Screening: Screening for Depression and Follow-Up Plan	134	CMS2v11

* eCQM versions listed are specific to the 2022 performance year. For different performance years, refer to the appropriate measure version.

A collection type refers to the way data is collected for a MIPS quality measure. Data for one measure may be collected in multiple ways. Each collection type has its own specification (instructions) for how to report that measure and meet the data completeness/case minimum requirements. ACOs will need to consider if they'll submit their own quality data or work with a third party intermediary to submit data on their behalf. Tables 2 and 3 summarize the characteristics of the MIPS CQM and eCQM collection types.

Table 2: Summary of the MIPS CQM Collection Type

	MIPS CQM
Specifications Summary	Measure specification document includes a narrative description of the specifications, measure flow, corresponding codes, and the associated algorithm for the application of logic for data completeness and performance.
Eligible Population	For ACOs, the patient population eligible for quality reporting consists of the universe of the aggregated ACO participant's all patient population, inclusive of all patients across ACO participant TINs, after patient matching and deduplication.
Measurement Period	12 months: Jan. 1 – Dec. 31 of the given performance period.
Data Sources and Coding	**Denominator Codes:** May include CPT, HCPCS, ICD-10-CM, and ICD-10-PCS codes. Does not utilize LOINC, ICD-9-CM, or SNOMED CT codes. Does not utilize RxNorm drug codes; if applicable, drug names included in narrative specification.

	MIPS CQM
	Numerator Codes: Includes the option of using QDCs (CPT II and/or HCPCS codes) that indicate if the quality action was met or not met and a value or range if applicable. Data sources utilizing other code systems can be used to support the use of a QDC code for numerator compliance, based on manual abstraction of data or the compilation of electronic data and mapping of comparable codes. Codes are included in the measure specification document.
Data Completeness Criteria	ACO submissions must include 100% of eligible and matched patients across all ACO participants' (i.e., TINs) patients. The ACO must also meet a data completeness threshold of 70% for 2022 and 2023 performance years, increasing to 75% for 2024 and 2025 performance years.[3] This means that performance data (i.e., "Met" or "Not Met," or denominator exceptions) should be present for at least 70% or 75%, as applicable, of the eligible and matched patients that meet the measure's denominator criteria.
Data Submission	MIPS CQMs may be collected by third party intermediaries (TPIs) such as CMS approved Qualified Registries or Qualified Clinical Data Registries (QCDRs), aggregated to the ACO level and submitted (via Direct or Log-in and Upload submission types) on behalf of the ACO. ACOs may also aggregate and submit their data directly to CMS.
Resources	For specific guidance on how to report the MIPS CQM measures and for more information pertaining to Qualified Registries or Qualified Clinical Data Registries (QCDRs), please refer to the QPP Resource Library (https://qpp.cms.gov/resources/resource-library) and search for "2022 MIPS Guide to Using a QCDR or Qualified Registry." The 2022 Qualified Registry Qualified Posting and 2022 Qualified Clinical Data Registries (QCDRs) Qualified Posting are linked on page 2 of the guide. For resources to assist in data submission, please refer to Developer Tools (https://qpp.cms.gov/developers).

[3] *See* CY2022 Physician Fee Schedule Final Rule (to be codified at 42 C.F.R. § 414.1340(a) and (b)), available at https://www.federalregister.gov/d/2021-23972.

Table 3: Summary of the eCQM Collection Type

	eCQMs
Specifications Summary	The published version of an eCQM is posted as a measure package, which includes human readable and machine-processable files. The measure specification document includes a narrative description of the specifications and measure logic (i.e., Boolean logic) represented by Clinical Quality Language (CQL) logic and the Quality Data Model (QDM). • CQL expresses the measure logic. Use of CQL shared functions and definitions facilitates greater consistency across measures. • The QDM serves as the data model for describing data elements. A QDM data element is defined through a combination of a QDM datatype, and a value set or direct reference code. The value set corresponds to a list of codes.
Eligible Population	For ACOs, the patient population eligible for quality reporting consists of the universe of the aggregated ACO patient population, inclusive of all patients across ACO participant TINs, after patient matching and deduplication.
Measurement Period	12-months: Jan. 1 – Dec. 31 of the given performance period.
Data Sources and Coding	Coding systems may include CPT, HCPCS, SNOMED CT, LOINC, ICD-9-CM, ICD-10-PCS and ICD-10-CM codes. Includes RxNorm drug codes. Includes Demographic codes (i.e., sex, race, ethnicity, payer, etc.). Codes are available to download via excel spreadsheets and API from the Value Set Authority Center (VSAC). EHR systems certified by ONC use patient data (i.e., codes) to calculate results for each measure. For the CY 2022 reporting period, ACOs may utilize the 2015 Edition CEHRT, the 2015 Edition Cures Update, or a combination of both. For the CY 2023 reporting period, ACOs must utilize EHR systems updated to the 2015 Edition Cures Update. Per regulations, EHR system should be capable of exporting CQM data formatted to the Quality Reporting Document Architecture Category I (QRDA I) standard, https://www.federalregister.gov/d/2015-25597/p-693. QRDA I data is used to export patient level detail and is aggregated to the QRDA III.

	eCQMs
Data Completeness Criteria	The ACO must meet a data completeness threshold of 70% for 2022 and 2023 performance years, increasing to 75% for 2024 and 2025 performance years.[4] Since eCQMs are specified to be calculated using all-payer data and submitted electronically without any manual manipulation such as the exclusion of certain cases, ACOs that submit eCQMs via CEHRT would generally achieve 100% data completeness by virtue of the eCQM end-to-end electronic reporting.
Data Submission	ACOs have 2 file format options for data submission for eCQMs. Report directly to Quality Payment Program (QPP) using the QPP Website using either: 1). A Quality Reporting Document Architecture Category III (QRDA III) file; or 2). A QPP JavaScript Object Notation (JSON) file
Resources	For additional information and eCQM specifications, please refer the eCQI Resource Center. The eCQM versions listed are specific to PY2022. For different performance years, refer to the appropriate measure version. • 001 eCQM CMS122v10 - Diabetes: Hemoglobin A1c (HbA1c) Poor Control • 134 eCQM CMS2v11 - Preventive Care and Screening: Screening for Depression and Follow-up Plan • 236 eCQM CMS165v10 - Controlling High Blood Pressure For resources to assist in data submission, please refer to Developer Tools (https://qpp.cms.gov/developers).

The eCQMs use the Clinical Quality Language (CQL) to express measure logic. This allows a computer to process the measure specifications and place patients in the appropriate populations based on the logic. There are eCQM flow diagrams that provide an overview of a measure's population criteria. However, the complete list of data elements and criteria for the eCQM specification is represented in the CQL logic. The MIPS CQM logic, on the other hand, is designed as a visual walkthrough of the measure algorithm with a series of decisions for

[4] *See* CY2022 Physician Fee Schedule Final Rule (to be codified at 42 C.F.R. § 414.1340(a) and (b)), available at https://www.federalregister.gov/d/2021-23972.

determining if a patient qualifies for each criterion. This algorithm would be applied by an ACO or vendor to calculate performance results after compiling available electronic data files.

3. Eligible Population

When reporting eCQMs or MIPS CQMs, the ACO will identify the eligible patient population to be reported on as defined in the individual measure specifications. For ACOs, the eligible and matched population will be used, meaning that any patients removed from the data due to matching and deduplication prior to submission are not included in the eligible population. It is important to note that ACOs are reporting on behalf of eligible clinicians from all ACO participants (i.e., TINs). This means that the ACO submission should include aggregated patient data for all matched and deduplicated patients across all ACO participant TINs, for eligible patients as defined in the eCQM initial population criteria or MIPS CQM denominator population. For example, the initial population for the following MIPS quality measure, Controlling High Blood Pressure (MIPS Quality Measure #236), is defined as "patients ages 18-85 who had a visit and a diagnosis of essential hypertension starting before and continuing into or starting during the first 6 months of the measurement period". The measure denominator will equal this initial population after patient matching and aggregation is applied and after applying denominator exclusions and exceptions as defined by the measure specifications. For example, for MIPS Quality Measure #236, exclusions are defined for patients with advanced illness or dementia.

4. Patient Matching and Data Aggregation

An ACO's selected collection type (i.e., eCQM or MIPS CQM) may impact the way in which it aggregates data for the purposes of reporting a measure at the ACO level. For example, an ACO reporting eCQMs from a single EHR using CEHRT might not need to aggregate data outside of the CEHRT because eCQMs are an end-to-end electronic reporting method and, consequently, capture 100% of a measure's numerator and denominator for the initial population. If an ACO is able to capture its full eligible population through multiple EHRs using CEHRT, aggregation and patient matching and deduplication across the EHRs would be necessary prior to submission of eCQM performance. For ACOs using the MIPS CQM collection type, the measure specifications allow for the use of multiple data sources and thus necessitate patient matching, deduplication and aggregation of data across all sources.

To remain aligned to the eCQM and MIPS CQM measure specifications through the collection, aggregation, and submission process, ACOs and their supporting vendors should employ the most suitable and technologically feasible methods that best fit their capabilities and workflows and provide the most complete and accurate data to meet the measure.

Patient matching, parsing, and data cleansing may rely on a combination of available variables. ACOs that have experience reporting eCQMs and MIPS CQMs have described success in achieving patient matching rates of 90% or higher using common variables such as: first name, last name, date of birth, phone number and email. Under current CEHRT requirements, EHRs are required to support each of these data elements for certification. ACOs have also indicated the benefits of using solutions such as an Enterprise Master Patient Index (EMPI). While variable selection and matching criteria may vary across organizations, ACOs should identify an appropriate combination of variables to achieve consistent and replicable patient matching that provides the most complete and accurate data to meet the measure specification and valid and reliable measure performance.

CMS may request the ACO's technical documentation and internal organizational policies that document the ACO's approach to patient matching, parsing, and data cleansing to ensure that the ACO's reporting is true, accurate, and complete at the ACO level.

5. Data Completeness

Data completeness refers to the quality performance data reported for a specified proportion of a measure's eligible population. To meet the data completeness criteria, ACOs must report quality performance data ("Performance Met", "Performance Not Met" or denominator exceptions) for at least 70% of the eligible and matched denominator population, regardless of payer.[5] The standard will increase from 70% to 75% for the 2024 and 2025 performance years.[6] An aggregated ACO submission must account for 100% of the eligible and matched patient population across all ACO participants. Data completeness is calculated based on submitted data.

True, Accurate and Complete Reporting

Sections 414.1390(b) and §414.1400(a)(5) provide that all MIPS data submitted by or on behalf of a MIPS eligible clinician, group, virtual group, APM Entity, opt-in participant, and voluntary participant must be certified as true, accurate, and complete. Incomplete reporting of a measure's eligible population, or otherwise misrepresenting a clinician or group's performance (e.g., only submitting favorable performance data), would not be considered true, accurate, or complete.

Since eCQMs are specified to be calculated using all-payer data and submitted electronically without any manual manipulation, ACOs that submit an eCQM via CEHRT would generally achieve 100% data completeness. The eCQM contains data regarding 100% of the eligible clinicians' matched patient population and its end-to-end electronic reporting ensures no cases

[5] 42 C.F.R. § 414.1340(a) and (b) (2021).
[6] *See* CY2022 Physician Fee Schedule Final Rule (to be codified at 42 C.F.R. § 414.1340(a) and (b)), available at https://www.federalregister.gov/d/2021-23972.

are excluded from the submission. In the case of an ACO using multiple CEHRT, eCQM reporting thus requires the aggregation of data across all CEHRT used within the ACO into a single submission to ensure the ACO meets the measure specification by accounting for its complete patient population. ACOs using multiple CEHRT may alternatively consider reporting via MIPS CQMs.

Since MIPS CQM measure specifications allow for the use of multiple sources of data (e.g., EHRs, paper records, registries, claims data) to compile a measure's numerator and denominator, an ACO must undertake additional effort to ensure it meets the completeness standard. An ACO reporting via the MIPS CQM collection type must report performance data ("Performance Met," or "Performance Not Met" or denominator exceptions) for at least 70% or 75%, as applicable, of their eligible and matched population denominator.

CMS recognizes that ACOs may encounter unanticipated technical barriers or incomplete patient records as they work to identify their full eligible and matched population. CMS expects ACOs to coordinate inside and outside the ACO to report quality performance data where possible. Where CEHRT is not available across all ACO participant TINs or where CEHRT cannot effectively aggregate data to meet the data completeness standard, the ACO can opt for the MIPS CQM collection type to utilize available data sources including practice management systems, paper records, etc.

6. Performance Rate Calculation

Performance rate calculations for eCQMs differ from MIPS CQM measures in how unreported numerator performance is treated. Because eCQMs reflect end-to-end electronic reporting, data submitted via eCQMs is by definition 100% complete when submitted by CEHRT. For patients where numerator data is not submitted, the eCQM is scored as "Performance Not Met."

In contrast, MIPS CQM specifications allow for the aggregation of data from multiple sources, not exclusive to CEHRT. Any missing numerator data submitted via MIPS CQM will count against the entity's data completeness and not the performance rate. The impact on the performance rate calculated is shown in the examples on the following page:

Example Calculations:

eCQM

For the eCQM collection type, the initial population for the aggregated ACO Performance Rate calculation is equal to the Eligible and Matched Population of the ACO. The denominator equals the Initial Population or a subset of the initial population after the application of denominator exclusions and exceptions as defined in the measure specifications. Denominator exclusions are applied before determining if numerator criteria are met, and denominator exceptions are applied only if the numerator criteria are not met.

Table 4.

Initial Population	Denominator Exclusion	Denominator Exception	Numerator Exclusion	Performance Met	Performance Not Met	Data Completeness	Performance Rate
1000	50	0	N/A	700	250	100%	74%

In the example shown in Table 4, the Performance Rate = 700 / (1000 – (50 + 0)), or 74%. Stated differently, the eCQM Performance Rate equals the total number of "Performance Met" reported divided by the "Initial Population" minus any reported "Denominator Exclusions" and "Denominator Exceptions." Data completeness equals 100% since for eCQMs, the "Performance Not Met" number includes instances where performance data was identified but did not meet the measure performance target, and also instances where performance data was not identified within the EHR.

MIPS CQM

For MIPS CQM, the denominator for the Performance Rate calculation is equal to the numerator of the data completeness calculation (i.e., "Performance Met" + "Performance Not Met").

Table 5.

Initial Population	Denominator Exclusion	Denominator Exception	Performance Met	Performance Not Met	Numerator Data Not Reported	Data Completeness	Performance Rate
1000	50	0	700	200	50	94%	78%

In the example shown in Table 5, the Performance Rate = 700 / (700 + 200), or 78%. The MIPS CQM Performance Rate equals the total number of "Performance Met" reported divided by the sum of "Performance Met" and "Performance Not Met" reported. The data completeness calculation is ("Performance Met" + "Performance Not Met") / ("Initial Population" – "Denominator Exclusions" + "Denominator Exceptions."). Specific to this example the Data Completeness calculation is (700 + 200) / (1000 – (50 + 0)), or 94%. For MIPS CQMs, the "Performance Not Met" number only includes instances where performance data was identified but did not meet the measure performance target. It does not include instances where performance data was not submitted. Where performance data was not submitted, it counts against the Data Completeness calculation.

In both above examples, the 1000 "Initial Population" count for an ACO represents the total number of eligible and matched patients submitted. Any patients removed from the data due to matching and deduplication prior to submission are not included in the "Initial Population" and are not considered when calculating a measure's performance rate, data completeness, and case minimums.

7. ACO Reporting Scenarios

Scenario 1: ACO has Single CEHRT and Reports eCQM

Because there is a common patient identifier, patient matching across sources is not necessary. The patient-level data will be contained within a single CEHRT and the ACO level data can be reported out using a QRDA III or JSON format from the same CEHRT.

Scenario 2: ACO Includes Multiple Certified EHRs and Reports eCQM

For an ACO with multiple certified EHRs and without a common patient identifier, the ACO will need to aggregate the results and determine its approach for patient matching and deduplication in order to report via the eCQM collection type. All ACO participants' patient information will need to be collected, including the patient-level detail necessary for patient matching. ACOs with multiple instances of CEHRT should set up automated processes to gather patient records in a central repository and to patient match, deduplicate, and parse the records. Quality measure results would be calculated from these aggregated, standardized records using CEHRT, with outputs converted to QRDA III or JSON files. The ACO will submit these files with a single CEHRT credential.

Scenario 3: ACO Includes Multiple ACO Participants and Data Sources, and Reports MIPS CQMs

For an ACO not prepared to report via eCQM, then the MIPS CQM collection type would be the appropriate option. MIPS CQM measure specifications allow for the use of multiple sources of data (i.e., multiple EHRs, paper records, registries, patient management systems) to compile a measure's numerator and denominator. Quality performance can be determined using a certified patient registry or by the ACO. Individual patient data is matched and deduplicated by the registry vendor or ACO prior to populating the MIPS CQMs. ACOs or their vendor may submit in a JSON or QRDA III format.

8. Vendor Resources

For ACOs who chose to report via MIPS CQM using a third-party intermediary, the Quality Payment Program (QPP) maintains lists of Qualified Registries and Qualified Clinical Data Registries (QCDRs). Available via the QPP Resource Library, the *2022 Qualified Registries Qualified Posting* and *2022 Qualified Clinical Data Registries (QCDRs) Qualified Posting* each include lists of all entities that are authorized by the CMS to submit quality measures, Promoting Interoperability measures, and/or improvement activities on behalf of the MIPS eligible clinician, group, virtual group, Alternative Payment Model (APM) entity, voluntary participant, and/or opt-in participant for purposes of the 2022 MIPS performance year. Column K, "Reporting Options Supported," of this file denotes the vendors who declare to submit data on behalf of APM Entities. Within the 2022 Qualified Registries listing, 45 vendors indicate they support reporting quality measures to the APP at the APM Entity level: with most vendors supporting both eCQM and MIPS CQM measure specifications.

These entities are approved by CMS through the MIPS self-nomination process. Prior to selecting or using any specific entity or its products, ACOs should perform their own due diligence on the entity and its products, including contacting the entity directly to learn more about its products.

It is important to note that – while these postings provide exhaustive lists of Qualified Registries (QR) and Qualified Clinical Data Registries (QCDR) – they are not inclusive of all vendors that report through the QPP. For ACOs who chose to report via eCQM, the Office of the National Coordinator of Technology (ONC) maintains a searchable database of Certified Electronic Health record Technology (CEHRT) at CHPL Search (healthit.gov).

9. Resources

Electronic Clinical Quality Improvement (eCQI) Resource Center: https://ecqi.healthit.gov/.

- The "one-stop shop" for stakeholders engaged in electronic quality improvement.

MIPS CQM Measure Specifications: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1690/2022+Clinical+Quality+Measure+Specifications+and+Supporting+Documents.zip.

- Provides comprehensive descriptions of the 2022 Clinical Quality Measures (CQMs) for the Merit-based Incentive Payment System (MIPS) quality performance category.

Eligible Clinician eCQMs: https://ecqi.healthit.gov/ep-ec?qt-tabs_ep=1.

- Source of eCQM measure specifications

Eligible Clinician eCQM Flow Diagrams: https://ecqi.healthit.gov/ep-ec?qt-tabs_ep=0.

- The eCQM Flows can be found by selecting "Implementation Guidance" under Filter Resources. The link labeled eCQM Flows will provide a downloadable zip file that contains all the eCQM flow diagrams for the measures in the selected performance period.

CMS Web Interface Transition Guide: Getting Started with Merit-based Incentive Payment System (MIPS) Clinical Quality Measure (CQM) Reporting: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1794/CMS%20Web%20Interface%20Transition%20Guide%20-%20Getting%20Started%20With%20MIPS%20CQM%20Reporting.pdf.

AND

CMS Web Interface Transition Guide: Getting Started with Electronic Clinical Quality Measure (eCQM) Reporting: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1795/CMS%20Web%20Interface%20Transition%20Guide%20-%20Getting%20Started%20with%20eCQMs.pdf.

- While these 2 resources are intended for MIPS Clinicians and Groups reporting via traditional MIPS and therefore does not address the additional steps of data aggregation required for ACOs, these documents provide helpful information regarding MIPS CQMs and eCQMs and steps required for implementation.

2022 MIPS Guide to Using A QCDR or Qualified Registry: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1749/2022%20MIPS%20Guide%20to%20Using%20a%20QCDR%20or%20Qualified%20Registry.pdf.

2022 MIPS Historical Quality Benchmarks: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/608/2022%20Quality%20Benchmarks.zip.

- Included in zip file posted on QPP Resource Library, https://qpp.cms.gov/resources/resource-library.
- Includes MIPS benchmarks for eCQM and MIPS CQM quality measures, updated annually.

Developer Tools: https://qpp.cms.gov/developers.

- Resources to assist in data submission, preview testing, APIs, QRDA III Conversion Tool.

Group and/or Individual Data Submission for MIPS: https://www.youtube.com/watch?v=q0Cvke6fnrghttps://www.youtube.com/watch?v=q0Cvke6fnrg.

- This video shows users who represent groups and/or individual clinicians how they can submit data for The Merit-based Incentive Payment System (MIPS) program.

Value Set Authority Center (VSAC): https://vsac.nlm.nih.gov/.

- Provides the ability to develop value sets from the Unified Medical Language System (UMLS) terminologies.

Qualified Registry Qualified Posting (XLS): https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1692/2022%20Qualified%20Registry%20Qualified%20Posting.xlsx.

- CMS publishes a list of approved organizations (with contact information, services offered, pricing, and the specific quality measures they support) prior to the performance period. ACOs are not required to use an organization from this list.

Pew Charitable Trusts: Enhanced Patient Matching Is Critical to Achieving Full Promise of Digital Health Records: https://www.pewtrusts.org/en/research-and-analysis/reports/2018/10/02/enhanced-patient-matching-critical-to-achieving-full-promise-of-digital-health-records.

EHR Contracts Untangled: Selecting Wisely, Negotiating Terms, and Understanding the Fine Print: http://www.healthit.gov/sites/default/files/EHR_Contracts_Untangled.pdf.

10. Glossary

APM Entity. APM Entity group is defined as a group of eligible clinicians participating in an APM Entity, as identified by a combination of the APM identifier, APM Entity identifier, TIN, and NPI for each participating eligible clinician. The Medicare Shared Savings Program is an APM and the ACOs are APM Entities.

CDA. Clinical Document Architecture (CDA) is a popular, flexible markup standard developed by Health Level Seven International® that defines the structure of certain patient medical records, such as discharge summaries and progress notes, as a way to better exchange this information between healthcare providers and patients. Wallask, S. (n.d.). *Clinical document architecture (CDA)*. TechTarget: SearchHealthIT. Retrieved June 7, 2022, from https://searchhealthit.techtarget.com/definition/Clinical-Document-Architecture-CDA.

C-CDA. Consolidated Clinical Document Architecture is a complete architecture used to create documents and template methodologies for medical documents, primarily to standardize the content and structure for clinical care summaries. It is the most widely used format for health information exchange in the US today.

CEHRT. Certified electronic health record (EHR) technology. https://www.healthit.gov/topic/certification-ehrs/about-onc-health-it-certification-program.

Code System. A code system is a managed collection of concepts with each concept represented by at least one internally unique code and a human readable description, e.g., SNOMED CT. (https://ecqi.healthit.gov/glossary).

Denominator Exception. A denominator exception removes a patient from the performance denominator only if the numerator criteria are not met as defined by the exception.

Denominator Exclusions. Denominator exclusions describe a circumstance where the patient should be removed from the denominator. Measure specifications define denominator exclusion(s) in which a patient should not be included in the intended population for the measure even if other denominator criteria are applicable. Patients that meet the intent of the denominator exclusion do not need to be included for data completeness or in the performance rate of the measure.

eCQM. An electronic clinical quality measure (eCQM) is a clinical quality measure expressed and formatted to use data from electronic health record (EHRs) and/or health information technology systems to measure healthcare quality, ideally data captured in structured form during the process of patient care. For the measured entity to report an eCQM from an EHR, eCQM developers format the Health Quality Measure Format using the Quality Data Model to

define the data elements and Clinical Quality Language to express the logic needed to evaluate a provider or organization's performance. (https://ecqi.healthit.gov/glossary/ecqm).

HL7. Health Level Seven (HL7) International is a standards-developing organization that provides a framework and international standards for the exchange, integration, sharing, and retrieval of electronic health information (including clinical and administrative data) that supports clinical practice and the management, delivery, and evaluation of health services. These standards for transfer of data between healthcare software applications focus on the application layer, which is "layer 7" in the Open Systems Interconnection model (OSI model), a conceptual model that characterizes and standardizes the communication functions of a telecommunication or computing system without regard to its underlying internal structure and technology.

JSON. JavaScript Object Notation (JSON) is a lightweight data-interchange format. It is easy for humans to read and write. It is easy for machines to parse and generate. It is based on a subset of the JavaScript Programming Language Standard ECMA-262 3rd Edition - December 1999. https://www.json.org/json-en.html.

MIPS CQM. Merit-Based Incentive Payment System Clinical Quality Measure (MIPS CQM) Quality measures that can be calculated outside of CEHRT using manual data collection methods such as chart abstraction. MIPS CQMs are collected by CMS approved Qualified Registries and are submitted (via Direct or Log-in and Upload submission types) on behalf of MIPS eligible clinicians. (2022 MIPS Clinical Quality Measures Guide (cap.org))

National Provider Identifier (NPI). A unique 10-digit number used to identify clinicians.

Patient Registry. A patient registry is an organized system that uses observational study methods to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves a predetermined scientific, clinical, or policy purpose(s). https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/registries-evaluating-patient-outcomes-4th-edition.pdf.

Performance Met. If the intended quality action for the measure is performed for the patient.

Performance Not Met. When the denominator exception does not apply and the quality action was not provided. A lower calculated performance rate for this type of measure would indicate better clinical care or control. The "Performance Not Met" numerator option for an inverse measure is the representation of the better clinical quality or control.

QRDA. The Quality Reporting Document Architecture (QRDA) is the data submission standard used for a variety of quality measurement and reporting initiatives. It is based on the Health Level Seven International® (HL7®) Clinical Document Architecture (CDA). QRDA creates a standard method to report quality measure results in a structured, consistent format and can be used to exchange eCQM data between systems.

(https://ecqi.healthit.gov/qrda#:~:text=The%20Quality%20Reporting%20Document%20Architecture,Clinical%20Document%20Architecture%20(CDA).

QRDA I. QRDA I is an individual patient-level report. It contains quality data for one patient for one or more eCQMs.

QRDA III. QRDA III is an aggregate quality report. It has been expanded to support the exchange of Promoting Interoperability measures and improvement activities for the CMS Quality Payment Program. A QRDA III report contains quality data for a set of patients for one or more eCQMs, Promoting Interoperability measures, and/or improvement activities.

Taxpayer Identification Number (TIN). An identification number used by the Internal Revenue Service (IRS) in the administration of tax laws. Taxpayer Identification Number (TIN) means a federal taxpayer identification number.

Value Set. A value set is a list of specific values, terms, and their codes, used to describe clinical and administrative concepts in the quality measures. Value sets provide groupings of unique values along with a standard description or definition from one or more standard vocabularies used to describe the same clinical concept, e.g., diabetes, clinical visit, demographics, within quality measures. Examples of standard vocabularies used to support effective, interoperable health information exchange include SNOMED CT, RxNORM, and Logical Observation Identifiers Names and Codes. (https://ecqi.healthit.gov/glossary).

11. FAQs

Quality Reporting by Specialists:

Question: Are specialists' patients included in our ACO's eCQM and MIPS CQMs measure submission?

Response: When reporting at the ACO level, you are reporting on behalf of all of your ACO participants patients, which depending upon the measure's denominator may include the patients of specialists. This means that your submission should include aggregated, eligible and matched all patient data for all clinicians from ACO participant TINs in the ACO, including specialists' patients that meet the measure criteria. The ACO should coordinate with the health care providers inside and outside the ACO to meet the numerator criteria.

File Formats for eCQM Collection:

Question: Should ACOs submit to CMS a QRDA I file for every patient associated with the ACO participant TINs?

Response: No, ACOs should aggregate data prior to submission and submit a single file to CMS. CMS will not aggregate files on behalf of the ACO. Please note that a QRDA I file is just one way that the ACO participant can get all patient level data. There are numerous ways and

formats that the ACO can receive this data from ACO participants. We suggest organizations implement formats and processes that best fit their workflows to meet CMS's submission requirements, including data completeness requirements

Question: Please clarify the file format(s) required for ACO submission of eCQMs.

Response: When submitting quality data to MIPS via the eCQM submission method, ACOs can submit a Quality Reporting Data Architecture Category III (QRDA III) or QPP JavaScript Object Notation (JSON) file. When reporting the APM Performance Pathway (APP), your file must include the appropriate program name to be counted towards the APP. For example, when submitting a QPP JSON file, “programName” = “app1”.

Refer to the QPP Submission Measurement Sets API documentation for more information.

Link: https://cmsgov.github.io/qpp-submissions-docs/measurement-sets.

Also, see the 2022 CMS QRDA III Implementation Guide for Eligible Clinicians and Eligible Professionals for more information: Link: https://ecqi.healthit.gov/qrda.

Submission Scenarios:

Question: Are ACOs required to submit using one collection type? For example, could we submit 2 measures as eCQMs and one as a MIPS CQM?

Response: ACOs can select a different collection type for each measure. For example, an ACO could collect performance data via eCQM for 1 measure and via MIPs CQMs for the other 2. Each measure would be scored according to the specifications and benchmarks for its collection type. However, an ACO cannot combine collection types for a single measure. For example, an ACO could not collect performance data via eCQM from some ACO participant TINs and via MIPs CQMs for other ACO participants TINs and combine those results for the same measure.

Question: What happens if I have multiple submissions over the course of the submission period?

Response: CMS allows quality measures to be submitted through multiple collection types and uses the highest results to calculate an ACO’s MIPs quality performance category score. If the same quality measure is reported multiple times by the same organization through the same collection type, the system will save the most recently reported data for that specific measure. CMS won’t aggregate data from multiple submissions when the same measure is reported multiple times. If the same quality measure is reported by 2 different organizations, for example, your ACO uploaded a file with Measure 001 and your third party intermediary uploaded a file with Measure 001, CMS will use whichever submission resulted in a higher score for Measure 001. ACOs are encouraged to submit data early in the submission period to allow time for addressing any technical issues with submission.

Data Privacy:

Question: Can ACO providers and non-ACO providers share all-payer data? Is this a HIPAA violation? Can beneficiaries request to have their data excluded from quality reporting?

Response: Data sharing in the context of reporting ACO quality performance is allowed under HIPAA. The CMS regulatory requirement on HIPAA covered health care providers to disclose protected health information (PHI) of patients supersedes the HIPAA Privacy Rule right to request restriction at 45 CFR 164.522(a)(1)(vi). Therefore, HIPAA covered health care providers may disclose the PHI to CMS, consistent with the CMS regulatory requirement, regardless of any request by the individual to restrict the disclosure under the Privacy Rule. An individual may make the request to restrict the provider from disclosing the PHI to CMS, but the provider is not required by the Privacy Rule to agree to the request for restriction.

FQHC ACO Participants:

Question: My ACO includes Federally Qualified Health Centers, (FQHCs). Do I include FQHC patients in my eCQM or MIPS CQM submission to CMS?

Response: Yes, when an ACO aggregates its data for submission to CMS, if that ACO has an ACO participant TIN that is a Federally Qualified Health Center (FQHC), the ACO's submission should include data from that ACO participant TIN as applicable based on the measure specifications and eligible and matched patients.

Revision History

Date	Change Description
3/14/2023	Added clarifications regarding use of CEHRT.
12/12/2022	Original Posting.