AMA
AMERICAN MEDICAL ASSOCIATION

James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT

james.madara@ama-assn.org

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: Data Completeness and eCQM Adoption

Dear Administrator Brooks-LaSure:

The American Medical Association (AMA) is writing to express our strong concern with the Centers for Medicare & Medicaid Services (CMS) continued desire to increase the data completeness requirements for satisfying and successfully reporting on a quality measure within the Merit-Based Incentive Payment System (MIPS) program and Medicare Shared Savings Program (MSSP). Since 2020, CMS has required physicians to successfully report on a quality measure for 70 percent of all eligible patients (otherwise known as data completeness requirement within the MIPS program). Starting in 2024, CMS will increase the data completeness requirement to 75 percent of all eligible patients. In addition, starting in 2024, Accountable Care Organizations (ACOs) participating in the MSSP must report their quality measures through electronic clinical quality measures (eCQMs) and MIPS Clinical Quality Measures (CQMs). We believe there is a lack of understanding with the maturity of health information technology (health IT) standards to seamlessly aggregate data from electronic health records (EHRs) or registries from physicians who practice at multiple sites or as a part of an ACO to meet this increased bar. **We urge CMS to work with the physician, ACOs and the EHR vendor community to find solutions to these data aggregation problems and until the technology standards are more mature, CMS should reduce the quality measure data completeness requirement within MIPS and delay mandatory eCQM adoption for ACOs.**

We also urge CMS to re-open the finalized policy and provide an opportunity for stakeholders to weigh-in on the interoperability challenges. Challenges include lack of agreed upon semantic and syntactic standards, data privacy concerns, and patient misidentification. Many physician practices also lack knowledge on how to access providers' "digital endpoints" to collect the data needed for aggregation.

To justify the increased requirement, it is our understanding that there is a perception within CMS that the reporting rates it is receiving for many of the eCQMs within MIPS are 100 percent.[1] This may be the case for physicians who practice at one site of service and bill under a single taxpayer identification number

[1] Center for Medicare and Medicaid Services (CMS). Medicare Shared Savings Program Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Performance Pathway (APP) Guidance. Posted 12/12/2022.

(TIN). However, we do not believe that vendors truly understand what is intended with data completeness and therefore the percentage received by CMS does not accurately capture the eligible population for each TIN. Some physicians and almost all ACOs provide services across multiple sites using the same National Provider Identifier or TIN combination but not all sites (including across sites of service) may participate in MIPS, the registry, or EHR that the physician opts to use for MIPS reporting. Therefore, vendors or practices are just capturing the cases within a single EHR/site, which appears to be 100 percent, but excluding the eligible encounters from other sites of service.

We offer the following examples to illustrate the issue:

Example 1 - Specialty practice with Vendor X as their EHR

The specialty practice uses the EHR vendor to report their quality measures. Several physicians at the practice also provide care at two local skilled nursing facilities (SNFs).

Because one of the SNFs also uses Vendor X and has systems set up to enable data sharing with this TIN, Vendor X can include the data in what is reported for MIPS. The other SNF uses Vendor Y and is unable to share data with the practice. Data sharing roadblocks include lack of agreed upon semantic and syntactic standards, data privacy concerns, and patient misidentification. Many physician practices also lack knowledge on how to access providers' "digital endpoints" to collect the data needed for aggregation. To be clear, purposeful information blocking is unlikely the cause in this instance. Lack of technical capability and awareness are the main culprits.

As a result, Vendor X is not aware of how many patients from that SNF could be eligible for the measure and they do not include the SNF's data from Vendor Y when aggregating the data for MIPS reporting. In addition, the vendor has interpreted the data completeness requirement to mean that they must report all of the cases that are captured in the EHR system. Because of this misinterpretation of the data completeness requirements, the vendor reports a data completeness rate of 100 percent while unknowingly omitting the cases from the SNF from the denominator.

Example 2 - MSSP Participants

Interpretation of Guidance - ACO A

An ACO with one Certified EHR Technology (CEHRT) system (Vendor A) used across most participating TINs; however, a small number of the participating TINs are specialty practices and Federally Qualified Health Centers FQHCs, which use different CEHRT systems (Vendors B-D).

The ACO is able to collect data from all participant TINs on Vendor A so the ACO can aggregate the data and complete patient de-duplication before submitting a file to CMS. The ACO was unable to successfully extract and aggregate the data from the other TINs using Vendor B due to data privacy concerns. In addition, although the ACO practices are using CEHRT (Vendors C and D), some of the systems were only able to produce Quality Reporting Document Architecture (QRDA) III files so they are unable to de-duplicate patients. The ACO is also attempting to use billing claims for those practices that are still on paper. Using all these various methods, the ACO estimates a data completeness rate of at least 70 percent, based on the patient volumes. Here again, unaligned implementation of standards and unique customization choices made by CEHRT impact data completeness.

Interpretation of Guidance - ACO B

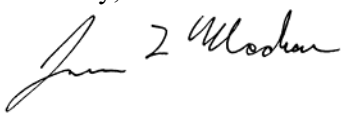
An ACO has 10 CEHRT EHR systems used across all participating TINs, including several small practices. The ACO is using an external vendor to assist with the data aggregation.

The ACO can collect data from most of the participant TINs. The small practices are unable to submit data to the ACO in the format needed to enable the de-duplication and aggregation steps that ACOs must complete before submitting a file to CMS because the vendor system used by them will charge an additional fee to support the eCQMs on which the ACO must report that they cannot afford. In addition, one practice changed vendors midyear and as a result is unable to produce the needed files for the reporting year. The ACO is not able to determine the number of individuals who could be included in the eCQMs' eligible populations so the ACO can either estimate the data completeness and report the measure without data from these practices or remove them from the ACO.

Furthermore, physicians are being held to a higher bar than any other CMS quality program. For example, health plans report on a sample of patients for each of the measures that require clinical data beyond administrative claims in the Medicare Part C and D Star ratings. Hospitals also abstract clinical data on a sample of patients for the clinical process of care measures. None of these sample sizes, which are based on the number of plan participants or individuals admitted to the hospital for a specific diagnosis or procedure, come close to the current 70 percent data completeness requirement in MIPS. If CMS determined that smaller sample sizes provide sufficient information on which CMS and others can make informed decisions on the quality of care delivered for health plans and hospitals, we believe that this same logic should also apply to MIPS.

Until physicians and other eligible clinicians can work within an environment where data and care are integrated seamlessly across settings, and providers, it is premature to continue increasing data completeness and encourage reporting through a registry or EHR (or require eCQMs/MIPS CQMs under MSSP). Current policy levers such as MIPS Promoting Interoperability requirements or Information Blocking regulations cannot alone resolve data completeness issues. Technology, standards, costs, and implementation decisions made by CEHRT developers will continue to impact the completeness of quality reporting. As previously stated, varying interpretations and assumptions about policy play a key role. Therefore, we urge CMS to work with physicians and developers to solve the data completeness factors we have outlined in this letter. For any questions, please contact Koryn Rubin, Assistant Director, Federal Affairs at koryn.rubin@ama-assn.org.

Sincerely,



James L. Madara, MD