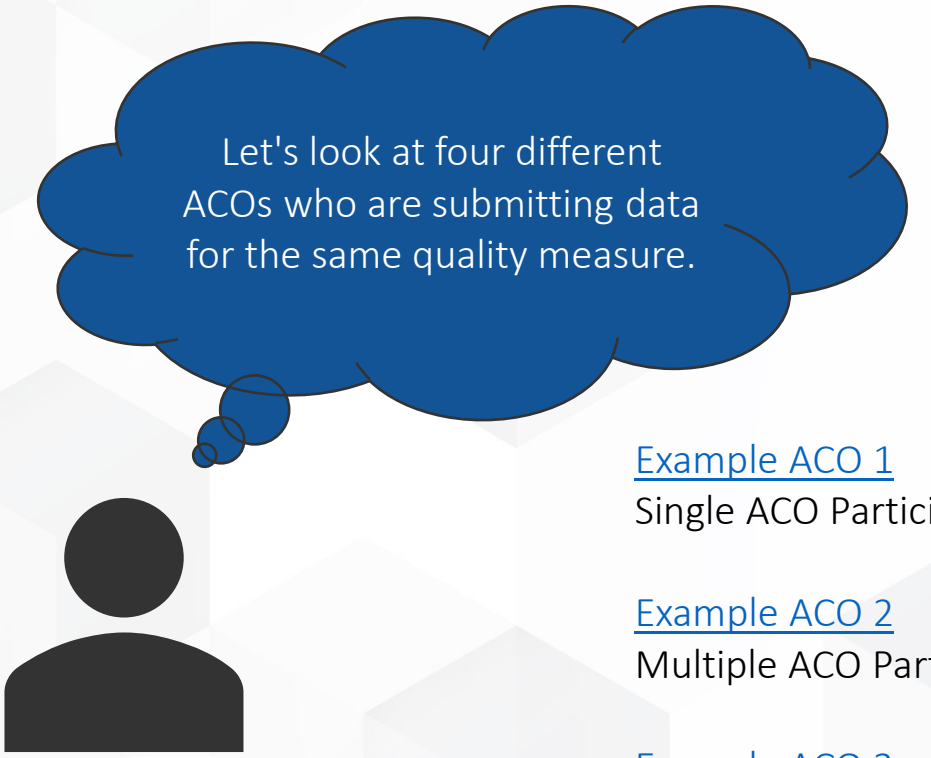
Quality Payment
PROGRAM

2024 Data Aggregation Resource

Data Aggregation

Prior to submitting quality measure data to the Quality Payment Program (QPP), Shared Savings Program Accountable Care Organizations (ACOs) must first determine whether to report using Electronic Clinical Quality Measures (eCQMs), Merit-Based Incentive Payment System Clinical Quality Measures (MIPS CQMs), or Medicare Clinical Quality Measures for Accountable Care Organizations Participating in the Medicare Shared Savings Program (Medicare CQMs).

Next, they need to aggregate patient data across all ACO participant Taxpayer Identification Numbers (TINs) and then de-duplicate the patient data.



Example ACO 1
Single ACO Participant TIN reporting eCQMs

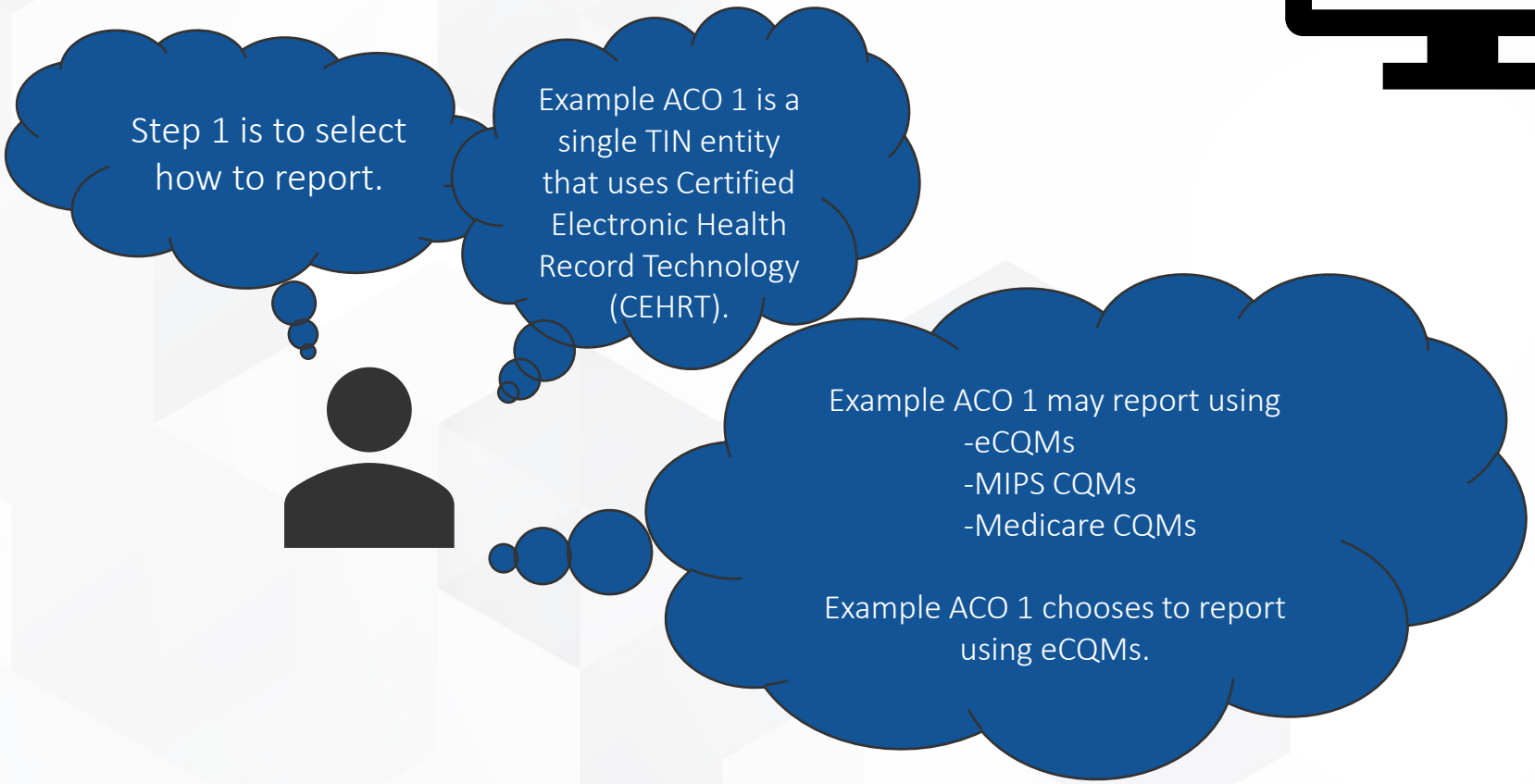
Example ACO 2
Multiple ACO Participant TINs reporting eCQMs

Example ACO 3
Multiple ACO Participant TINs reporting MIPS CQMs

Example ACO 4
Multiple ACO Participant TINs reporting Medicare CQMs

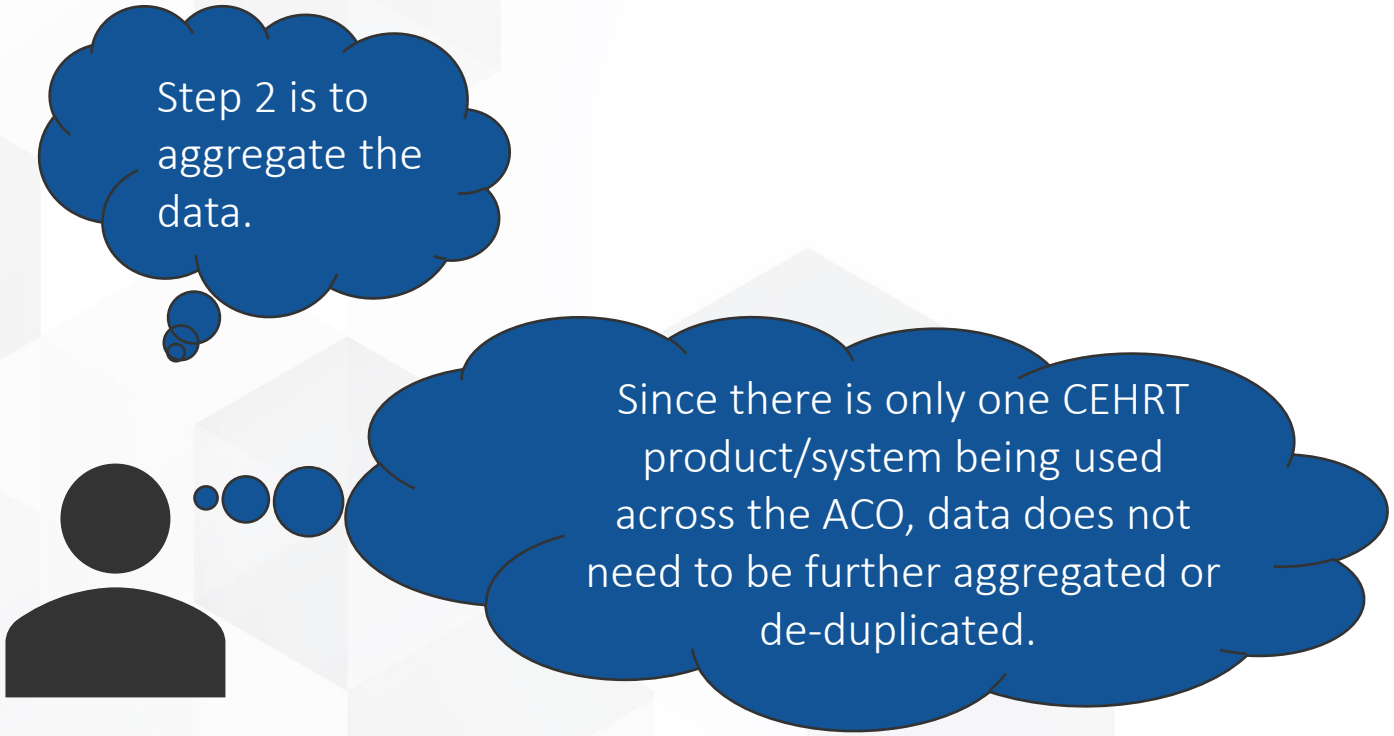
Step 1

Example ACO 1
Single TIN reporting eCQMs



Step 2

Example ACO 1
Single TIN reporting eCQMs



Step 1

Example ACO 2
Multiple TINs reporting eCQMs

Step 1 is to select how to report.

Example ACO 2 is a multi-TIN entity, each of which uses different CEHRT.

Example ACO 2 may report using:
-eCQMs
-MIPS CQMs
-Medicare CQMs

Example ACO 2 chooses to report using eCQMs.

Step 2

Example ACO 2
Multiple TINs reporting eCQMs

Step 2 is to aggregate the data.

Even if an ACO is able to capture all patient data for the measure through different CEHRTs, they still need to aggregate the data.

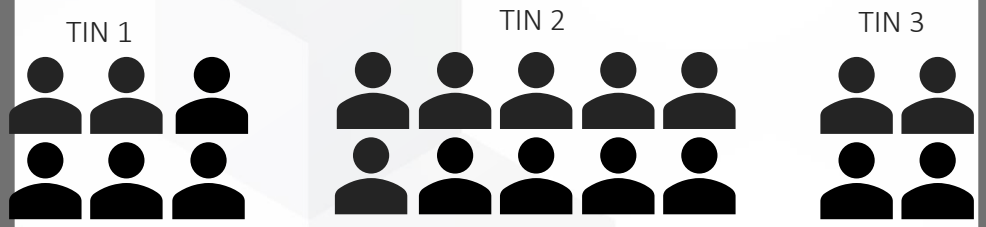
There are a total of 20 patients in the aggregated patient data.

Aggregation for eCQMs

Example ACO 2 has 3 TINs and each TIN saw a different number of patients last performance year:

TIN 1/CEHRT A = 6 patients total
TIN 2/CEHRT B = 10 patients total
TIN 3/CEHRT C = 4 patients total

Total across all TINs = **20 patients**



Step 3

Example ACO 2
Multiple TINs reporting eCQMs

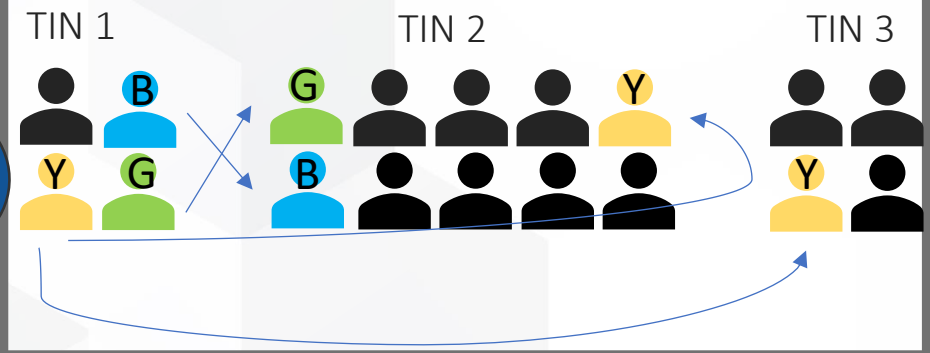
Step 3 is to de-duplicate the patient data to ensure that the same patient is not included multiple times for a measure.

For example, if patient B was screened for depression at TIN 1 and then later seen at TIN 2 where they were not screened for depression, not de-duplicating the data could result in the patient being counted as 2 unique patients: 1 who met numerator criteria and 1 who did not.

De-Duplication for eCQMs

Example ACO 2 now has to de-duplicate the patient data that was aggregated in step 2.
They have matched 3 patients that have duplicate records across all 3 TINs/CEHRTs:

Patient Blue (B) - Appears in TIN 1 & TIN 2
Patient Green (G) - Appears in TIN 1 & TIN 2
Patient Yellow (Y) - Appears in TIN 1, TIN 2 & TIN 3



Step 3 continued

Example ACO 2
Multiple TINs reporting eCQMs

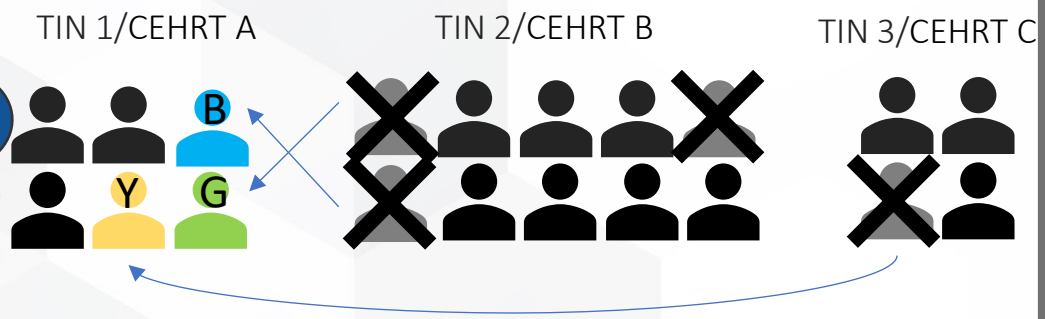
Once we remove the duplicate patient records, we find that the aggregated and de-duplicated total is 16 patients.

Note: If TIN 2 performed a quality measure for Patient B, they will still receive credit for the quality action or credit in the numerator.

De-Duplication for eCQMs (continued)

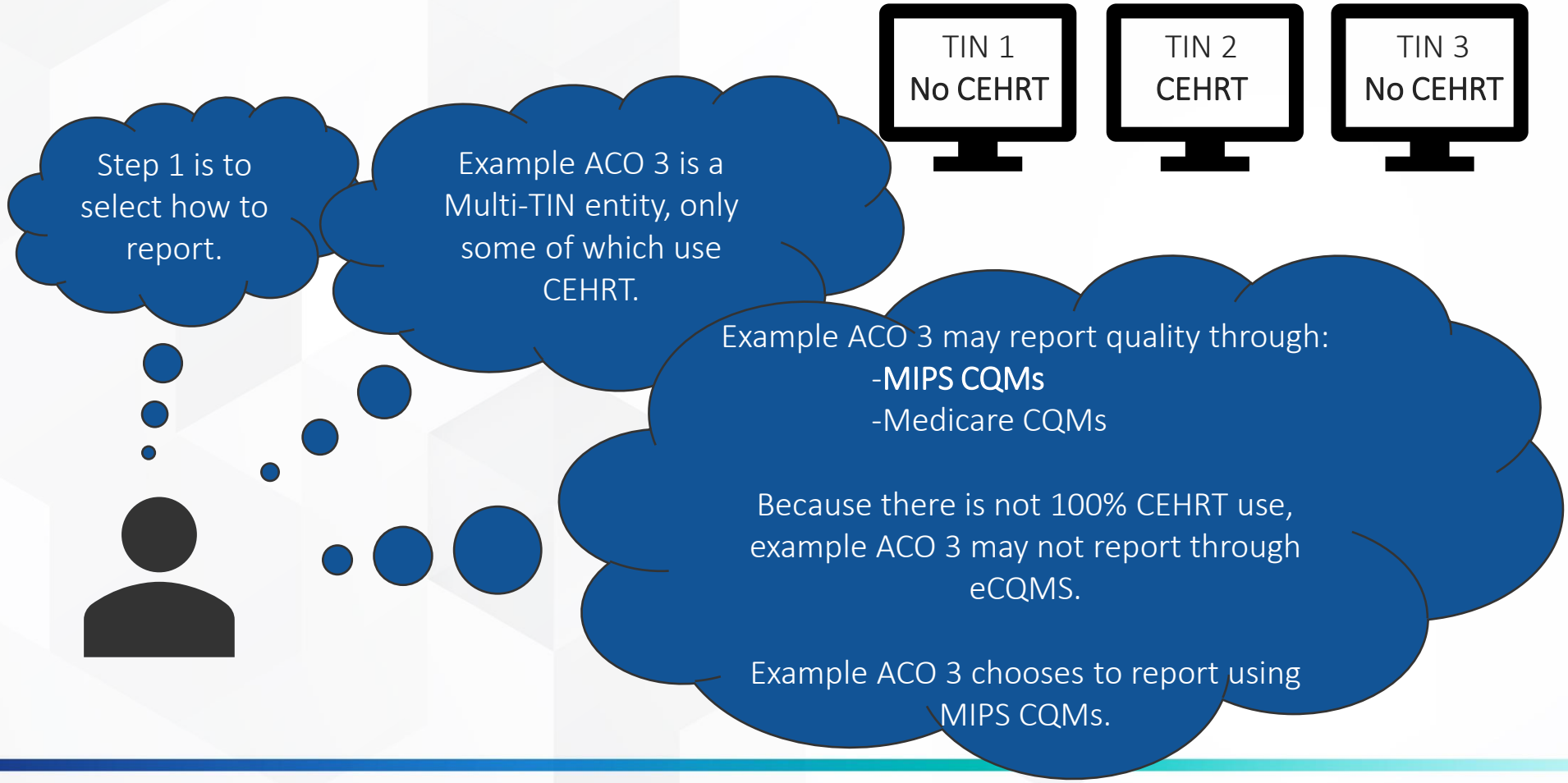
Once those patients' duplicate records are removed from the aggregate data, Example ACO 2 finds:

Aggregated & De-Duplicated Total = 16 Patients



Step 1

Example ACO 3
Multiple TINs reporting MIPS CQMs



Step 2

Example ACO 3
Multiple TINs reporting MIPS CQMs

Step 2 is to aggregate the data.

For ACOs using MIPS CQMs, the measure specifications allow for the use of multiple data sources, and data aggregation is required across all sources.

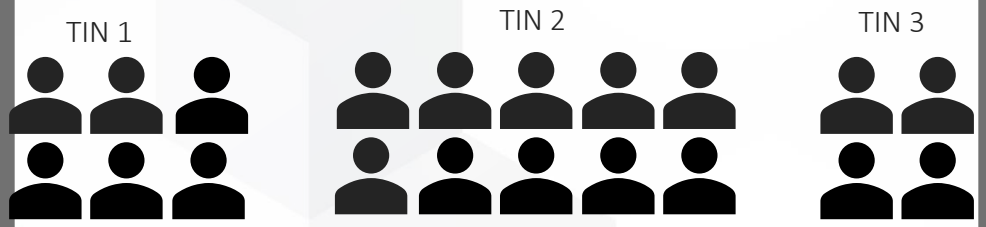
There are a total of 20 patients in the aggregated patient data.

Aggregation for MIPS CQMs

Example ACO 3 has 3 TINs and each TIN saw a different number of patients last performance year:

TIN 1 = 6 patients total
TIN 2 = 10 patients total
TIN 3 = 4 patients total

Total across all TINs = **20 patients**



Step 3

Example ACO 3
Multiple TINs reporting MIPS CQMs

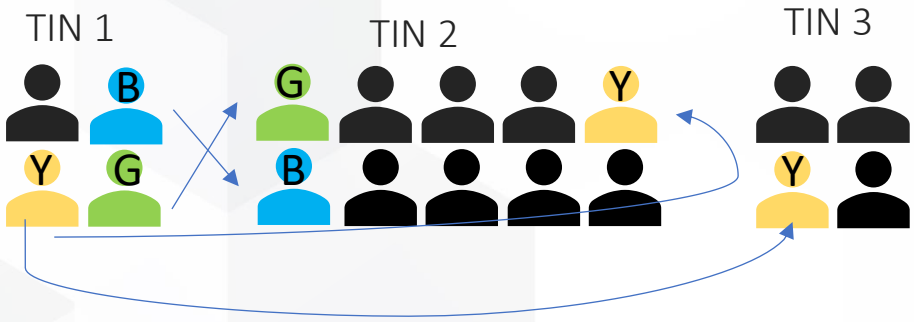
Step 3 is to de-duplicate the patient data to ensure that the same patient is not included multiple times for a measure.

For example, if patient B was screened for depression at TIN 1 and then later seen at TIN 2 where they were not screened for depression, not de-duplicating the data could result in the patient being counted as 2 unique patients: 1 who met numerator criteria and 1 who did not.

De-Duplication for MIPS CQMs

Example ACO 3 now has to de-duplicate the patient data that was aggregated in step 2.
They have matched 3 patients that have duplicate records across all 3 TINs:

Patient Blue (B) - Appears in TIN 1 & TIN 2
Patient Green (G) - Appears in TIN 1 & TIN 2
Patient Yellow (Y) - Appears in TIN 1, TIN 2 & TIN 3



Step 3 continued

Example ACO 3
Multiple TINs reporting MIPS CQMs

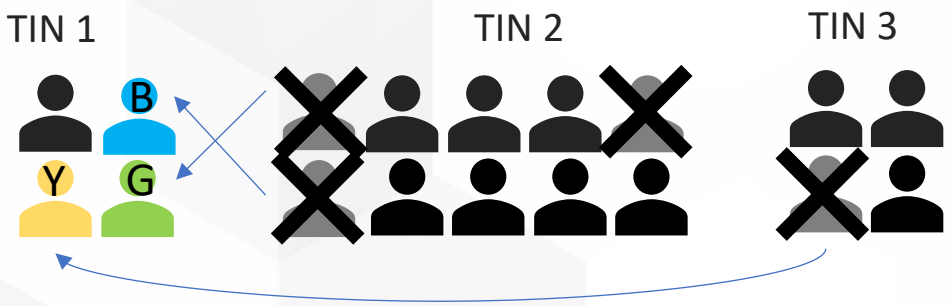
Once we remove the duplicate patient records, we find that the aggregated and de-duplicated total is 16 patients.

Note: If TIN 2 performed a quality measure for Patient B, they will still receive credit.

De-Duplication for MIPS CQMs (continued)

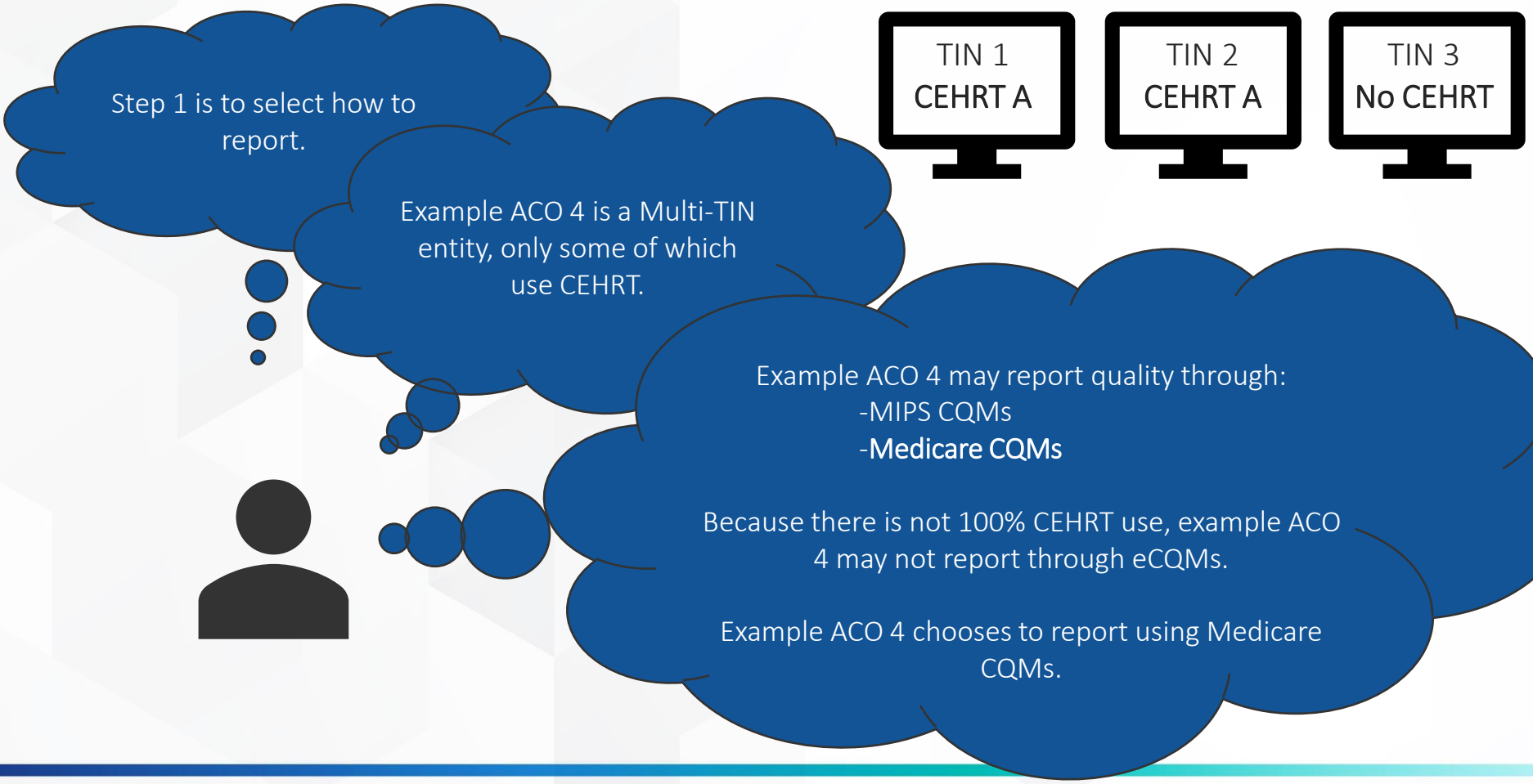
Once those patients' duplicate records are removed from the aggregate data, Example ACO 3 finds:

Aggregated & De-Duplicated Total = 16 Patients



Step 1

Example ACO 4
Multiple TINs reporting Medicare CQMs



Step 2

Example ACO 4
Multiple TINs reporting Medicare CQMs

Step 2 is to aggregate the data.

For ACOs using Medicare CQMs, the measure specifications allow for the use of multiple data sources, and data aggregation is required across all sources.

There are a total of 9 patients in the aggregated patient data received from CMS.

Aggregation for Medicare CQMs

CMS will provide a list of Medicare fee-for-service beneficiaries eligible for Medicare CQMs on a quarterly basis. The quarterly lists will also include beneficiary-level information to assist ACOs in identifying the eligible population for each measure. The final quarterly list for Quarter 4 contains information for all beneficiaries eligible for Medicare CQM reporting.

Example ACO 4 has 3 TINs. CMS sends the list Medicare fee-for-service beneficiaries eligible for Medicare CQMs:

TIN 1 = 3 patients total
TIN 2 = 4 patients total
TIN 3 = 2 patients total

Total across all TINs = 9 patients

Step 3

Example ACO 4
Multiple TINs reporting Medicare CQMs

Step 3 is to de-duplicate the patient data to ensure that the same patient is not included multiple times for a measure.

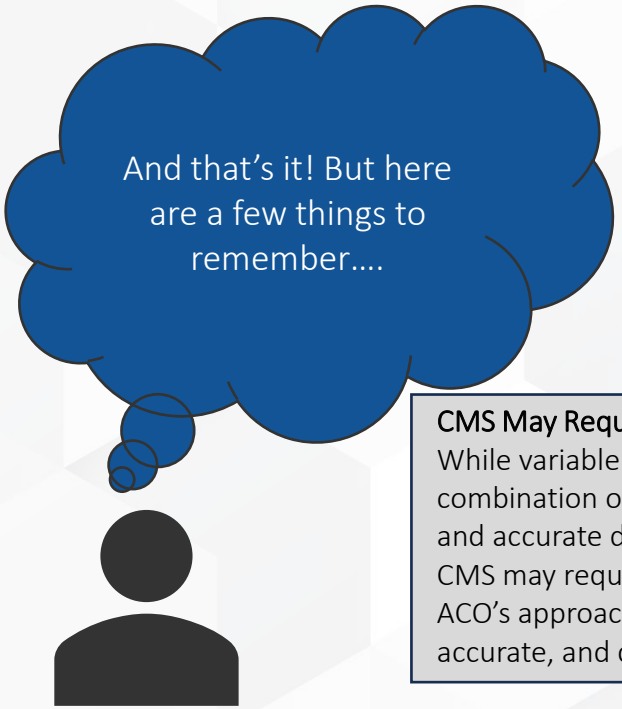
For example, if patient B was screened for depression at TIN 1 and then later seen at TIN 2 where they were not screened for depression, not de-duplicating the data could result in the patient being counted as 2 unique patients: 1 who met numerator criteria and 1 who did not.

De-Duplication for MIPS CQMs

Example ACO 4 now has to de-duplicate the patient data that was aggregated in step 2. ACO 4 does not identify any duplicate records.

TIN 1 = 3 patients total
TIN 2 = 4 patients total
TIN 3 = 2 patients total

Total across all TINs = 9 patients



Matching Duplicate Patient Records

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. ACOs have also indicated the benefits of using solutions such as an Enterprise Master Patient Index (EMPI). For ACOs using the Medicare CQM collection type, the Medicare Beneficiary Identification Number (MBIN) can be used for patient matching.

CMS May Request Technical Documentation

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.

Data Completeness

Before submitting data to CMS, ACOs also need to confirm they have met the data completeness requirement applicable for the performance year.

Submissions must include 100% of eligible and matched patients across all ACO participants' (i.e., TINs) patients. This is referred to as the "Initial Population" count for an ACO. 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.

For more information on Data Completeness, please see the 2024 Data Completeness Quick Start Guide.