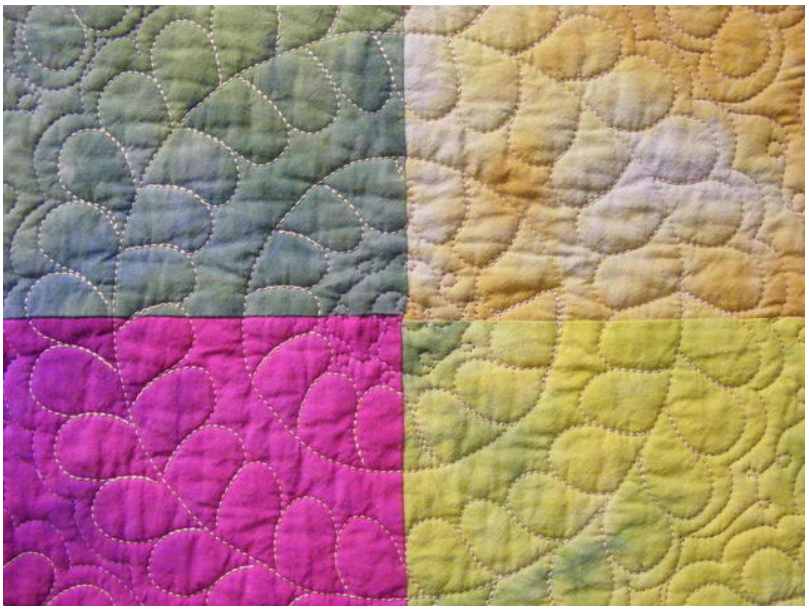
Proposed MACRA Rules Boost QCDR Development

written by Theresa Hush | May 11, 2016



One of the promises fulfilled by the new Proposed MACRA Rules, released April 27, is to position the Qualified Clinical Data Registry (QCDR) front and center. In fact, the Rules place the QCDR on par with the EHR in the spectrum of Health Care Information Technology (HIT) and give it special emphasis in Performance Improvement.

Yet the QCDR is mysterious to most providers. While providers and heath systems try to sort through all of MACRA recalculations for provider gain or loss under the new Quality Payment Programs, it can be easy to miss the simultaneous revolution in HIT to support these initiatives.

Why does it matter? Because as the last few years have taught us, hospital-based systems and provider organizations need more than their local EHR data, internal systems and organizations can deliver. To meet Medicare's timeframe for meeting better performance, they will need to make real strides in improving outcomes and efficiency now.

CMS has leveraged the QCDR in recognition that EHR data can be better connected to broad-based efforts to improve outcomes, and that it takes multiple external forces to harness change in the complex health care system.

What Makes a QCDR Different from Other Registries?

The QCDR was officially inducted in 2014, when CMS created a new method of meeting PQRS requirements through QCDR Reporting via a Registry that met a higher standard of data management, and provided an opportunity for measure development. The "Qualified" part comes from CMS sanctioning of the self-nominated Registry, partially based on performance

measures that are created and submitted by the Registry, using data that has come from provider systems. The "Clinical Data" part comes from a QCDR's ability to ingest EMR data, a distinguishing feature that was not present in many other PQRS Registries.

The pairing of higher data expertise and measure development sets the QCDR apart technically from other Registries. But more interesting is the distinction that the QCDR's PQRS reporting is inclusive of all patients, not just Medicare. This puts the QCDR at a strategic advantage to encourage organizations to use it as the centerpiece of an all-payer quality initiative.

How Has the Concept and Technology of the QCDR Grown Under MACRA?

QCDRs got a big boost under the Proposed MACRA Rules for MIPS. The Proposed Rules define the QCDR as a "CMS-approved entity that has self-nominated and successfully completed a qualification process to determine whether the entity may collect medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients." QCDRs are boosted throughout the Proposed Rules:

> QCDRs are called out as one of the limited methods for reporting all three non-CMS calculated areas of MIPS: Quality, Clinical Performance Improvement Activities and Advancing Care Information. Additionally, CMS is considering expanding this reporting capability to include costs.
> CMS specifically recommends the use of QCDRs for a variety of purposes beyond the development of performance measures—population management, long term clinical outcome data collection, performance feedback and clinical process improvements;
> Clinical Performance Improvement Activities can be met by working with QCDRs;
> QCDRs are specifically addressed as entities that are designed to improve performance;
> QCDRs will be allowed to submit EHR Incentive Program objectives and measures (they are currently allowed to report eCQMs if ONC certified).

In tandem with favorable positioning, however, QCDRs are also subject to a higher standard of performance, above and beyond using data standards and ensuring data:

> QCDRs will need to be able to perform risk adjustment on their own quality measures and provide for transparency in data, risk models and measures;
> QCDRs must provide timely feedback directly to providers on a regular basis and at least six times per year;
> QCDRs will need to have benchmarking capacity to compare physicians across quality measures, for non-MIPS measures.
> QCDRs must report outcomes over time, to allow assessment of improvement or worsening of conditions.

How is a QCDR Differentiated from an EHR for Providers?

For providers who have focused all their efforts on making the EHR the central technology for providers, the Proposed MACRA Rules may be disturbing. By design, CMS is focusing on adding more technology layers to an organization.

Is this technology layering simply an extra cost, or does the QCDR add something that an EHR cannot? Yes to the latter, depending on a variety of factors:

> Multiple-Practice Participation, including Private Practitioners. If your network is expansive and includes more than one EMR in use by your providers, the QCDR is a platform that can bring together all of your performance measurement and improvement. Data compared from EMR to EMR does not recognize that source data needs to be audited and validated, which a QCDR is designed to do.
> Benchmarking against a broader data set. Because the QCDR will have multiple clients in addition to your system, you benefit from both the experience of other organizations in performance improvement, as well as benchmarking against their data.
> Preparation for Alternative Payment Models. Significantly, MACRA pushes providers toward greater risk-sharing, based on both quality and cost. QCDR tools are as applicable to performance improvement in ACOs and Medical Homes as they are in organizations transitioning through MIPS, so a QCDR (especially not single specialty-based) should be able to facilitate a multi-specialty group's improvement from Fee for Service to risk, with consistent tools and reliable data. Since most APMs also have multiple practice participation, this is especially important.

How Should Providers Use the QCDR to a Strategic Advantage?

Apart from technology, the QCDR has a strong strategic advantage in creating a central platform for both Medicare and non-Medicare quality-based reimbursement programs. One of the grandest failures of past payer-based quality incentive programs was the generation of separate feedback programs, provider portals and results reporting sites for providers—who tuned out all the channels. The QCDR can help unify all quality programs, simultaneously validating the data, testing measure results and providing insight for the membership.

It cannot be overstated. The QCDR is a transformative tool for organizations that haven't even reported PQRS or that are still in the follow-up to EMR adoption. MACRA has financial ramifications for providers who participate in a failed quality enterprise. With the majority of ACOs not achieving successful savings targets, the provisions of MACRA for provider risk as well as reimbursement reductions will be onerous. The QCDR is the segue to risk. It allows providers the time to learn through the data and process of performance improvement, and become comfortable with technology, benchmarking and process change.

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