If Your Solution to PQRS Reporting Is an ACO, Think Again

written by Dave Halpert | April 6, 2016

Problems with PQRS reporting this year? As a Registry that works with groups ranging from Academic Medical Centers to solo practitioners, we've seen the whole gamut of issues. While there are no quick and easy solutions (sorry), the biggest myth we're hearing this year is that you can solve all your PQRS problems by forming an Accountable Care Organization (ACO).

It's certainly true that if your ACO reports successfully—and most do—you are not required also to report for PQRS. But before you take the huge organizational leap to forming or joining an ACO, you'd best read the fine print. For example, did you know that even though your ACO is covered for PQRS, you're still on the hook for the Value-Based Payment Modifier (VBPM or VM)? And that CMS will adjust your practice's Medicare Part B reimbursement based on the VM results of the entire ACO, even when your providers are not involved in an episode of care?

In short, an ACO is more than an alternate method of quality reporting. An ACO holds all involved to a higher standard. The challenge is not demonstrating that you can report quality data, but that you can affect care, as measured in outcomes and dollars. By starting or joining an ACO, you are saying that your data reporting methodology is neat and clean, and you're ready for the next step.

Quality Data Reporting Is Only the First Step Toward the Real Goal of Improved Outcomes

In order to improve outcomes—fewer hospitalizations for patients with chronic conditions, increased efficiency, lower costs—you need accurate and accessible data in order to develop a baseline and track your progress. Without the ability to measure your performance, you can't determine whether you are improving, stagnant or declining until Medicare analyzes results. In

other words, you are going to be the last to know whether your efforts to improve, either on a patient-by-patient basis or at the system level, had any impact.

Easier said than done. Even an expensive, customized Electronic Health Record (EHR) does not guarantee reliable (or even usable) data (all the more so for an "off-the-shelf" model). Likewise, using the same system as someone else is no guarantee that the data from your system bears any resemblance to theirs.

PQRS Reporting Errors Plague Groups Large and Small

We've dealt with a raft of data reporting issues, none of which are solved by shifting over to an ACO. Here are just a few examples of how faulty data were earmarked for use in reporting (including issues spawned by the biggest and most expensive EHR systems):

> "Native" coding, specific to the group's EHR. It may have meaning in one group's system, but is meaningless elsewhere. Your system may recognize "123" as a beta-blocker, but when trying to sync with another group that uses a standard system like NDC or RxNorm, you're setting the stage for errors.
> Quality Data Codes automatically appended by EHRs. Originally intended to make quality reporting easy for the EMR/EHR direct reporting option, this feature was often a patch, and the drawbacks are becoming clear. The issues fall into two categories:
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> > Codes indicating that an action was not performed at the time of the visit. The QDCs are applied in the background and may be false or misleading. The action in question may have actually been performed, or performed at a previous visit, or in another location, and didn't need to be repeated. However, the assigned code serves as an attestation that the provider did not perform a quality action, with no documented explanation.
> > Frequent use of codes that have been retired for years, and, in some cases, the measure has been retired as well.
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> A bounty of odd responses, whether coming from errors in data entry, data abstraction or data processing. This leads to responses like "Advanced Directive on File; Advanced Directive Not on File."

An ACO Is a Massive Administrative Undertaking, with Plenty of Room for Reporting Errors

Coding issues misrepresenting clinical quality are not the only pitfalls we've confronted. Medicare has addressed (and we've seen) instances where PQRS reports were rejected because the TIN in question (the level at which ACO participation is defined) was already in an ACO. The group did not realize that someone had signed them up! No one is immune—in the

last year, we've seen this happen in groups large and small. How can an ACO work to comprehensively improve outcomes and decrease costs when the group isn't even aware that their practice is engaged in the program?

"There's no way my practice could fall victim to any of that," you may be thinking. And you may well be right. But, can you say that with certainty about all of the other groups in your ACO? Competition is increasing and proposed benchmarking is more specific and stringent. If you've signed with an ACO and PQRS was one of your primary reasons for doing so, you may have put yourself in a precarious position.

Set Your ACO on the Path Toward Improved Outcomes with a Clinical Data Registry

The good news is that, even for those beginning to question if their decision to form or join an ACO was hasty, it's not too late to steer your ACO onto a better path. When looking at quality initiatives that go beyond basic reporting—programs like Bundled Payments and ACOs —the goals are the same, and measured similarly: make patients healthier, and demonstrate it by proving that their care costs less than it did before you started.

In addition to building a culture of forward-thinkers who are willing to examine rigorously what's working and what isn't, you'll need a technology partner who can assist you with quality data reporting and analysis of ACO claims. This is not a job solely for a clearinghouse, benefits or pure analytics company. Certainly, some have experience with claims and data, but that doesn't make them the right choice for your ACO, any more than you'd go to an orthopedist if you thought you might need glasses. An ACO is a job for a Clinical Data Registry that can provide these services:

> Provide specific and actionable data. Big data analytics are great. But if showing someone a chart were all it took, every ACO would easily have generated enough savings to share by now. You need to know which patients are at risk, define the root causes of your cost problems, and implement specific initiatives for named patients and patient groups. The management of your projects requires a level of detail that surpasses PQRS reporting. A CDR can help you to set priorities and manage the projects to improve performance. Its detailed scientific approach pivots on measurement, actions and analysis of data trends to guide you to better performance.
> Integrate disparate sources of data (and there will be deviations, even if using the same system as other partners in your ACO), along with CMS claims data to develop patient-centric records, and track those patients across the spectrum. Without that ability, "the right care at the right time" is impossible; services will be duplicated or missed.
> Define and establish discrete interventions with measurement of both outcomes and the

effectiveness of your interventions. Broad goals related to improved outcomes are fine, but the belief that care will improve on its own, by virtue of the ACO's existence or simply by sharing results with providers, is just plain false. A plan of action requires specific steps and measured progress. Groups will behave exactly as before the ACO unless you can define and implement interventions that work—and unless the groups really buy in, rather than simply pay lip service to the ACO so that they can skip PQRS.

Support the administrative infrastructure, in addition to quality improvement. If your ACO roster is being traded on spreadsheets or is otherwise inaccessible, you're already hamstrung. Make sure that your network infrastructure is captured for benchmarking with organizational targets and for comparisons between peer specialties and groups. Sharing data, which is a first step with providers, requires an architecture for your network and performance measurement process.

Provide tailored consultations and technology that is customized to your organization. A CDR should provide more than technology and help customize the data and technology to your ACO. There is no cookbook for ACO success. Your culture, providers and patients deserve solutions that will help you and your providers achieve success together.

A word of caution: Do not assume that, just because your technology partner has prestige, that they have these capabilities, or that these services are included in your agreement.

An ACO Is More Than an Alternate Reporting Method—It's an Alternative Payment Method

It is accurate to say that groups who are full ACO participants do not need to report PQRS. However, there's a reason that they're exempted. An ACO isn't merely an alternate reporting method; it is (and will become ever-increasing) an Alternate Payment Method (APM).

There is a great deal of additional responsibility and effort that goes into an ACO, which is one of the primary reasons that so many have been unable to earn Shared Savings. Those who join one primarily to avoid PQRS are setting themselves up for a big fall, particularly as PQRS gives way to MIPS, where ACOs are more at risk.

The bottom line: If you are experiencing the basic problems still prevalent in a simpler program like PQRS, beware of jumping into an ACO. If your group is already enrolled, take steps to determine whether the foundation of data and performance measurement is enough to be successful. You may have been able to go from zero-to-"PQRS Ready" in a week, but in an ACO, that's not an option—not if your aspirations include the real goal of improving health care outcomes while lowering associated costs.

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