How to Organize Your Academic Medical Center for PQRS 2015 Success

written by Dave Halpert | April 14, 2015

Take a deep breath. The last-minute flurry of adjustments and updates to last year's PQRS reporting is over. And—brace yourselves. It's time to dig into PQRS 2015, which, if you've been following our posts, requires a whole new level of rigor to avoid penalties under Pay for Performance. (Download our free eBook, *Insider's Guide to PQRS 2015 Reporting,* if you need to catch up.)

Nowhere are the new reporting complexities greater than for Academic Medical Centers (AMCs). Everyone is scrambling to ensure that workflow adjustments sync with new reporting requirements and general measure changes, but AMCs must contend with additional administrative challenges. In particular, they need to define which Eligible Professionals (EPs) are "on the hook" for measurement and then maintain uniformity across sites as providers come and go.

Here's why: Academic Medical Centers have the highest risk of all large providers for penalties under the Value-Based Payment Modifier (VBPM). The number of EPs billing claims under a practice's Tax Identification Number (TIN) is at the heart of PQRS reporting and the calculation of the VBPM. If the practice reports as individuals, at least 50 percent of the EPs must report successfully to prevent the practice from incurring a VBPM penalty (assessed even on those who reported successfully for PQRS). If the organization reports as a group practice, measure denominators must include all denominator-eligible instances. You cannot limit PQRS reporting to your full-time practitioners—everyone is counted.

Tallying the EPs who billed under an AMC's TIN is already a messy process. Some providers (Residents, for example) are rendering providers, but do not bill. For a variety of reasons, others practice infrequently. Some are seeing enough patients to retain hospital privileges, and others have schedules that require them to spend more of their time in the classroom and less in the clinic. Add to this the standard reasons for fluctuation—new hires, retirements and so on—and it's easy to see why Academic Medical Centers have a harder time getting any quality initiative up and running. Simply determining which providers are under measurement is like untying a Gordian knot (and we haven't even covered credentialing!).

Five Steps to Better PQRS 2015 Reporting for AMCs

So what's an AMC to do? Here are a few steps to take now to position your AMC for successful PQRS reporting for 2015:

Create a PQRS plan in advance that takes into account your past reporting results and your CMS quality tiering data for the VBPM. Based on this information plus knowledge of your data sources, you should be able to decide your best method of both reporting PQRS and optimizing your results under the Value-Based Payment Modifier. If you are unfamiliar with the CMS calculations that go into the VBPM or don't know how you will fare, consider working with experts, like a Registry that has services for both programs.

Create workflows within the practice to make sure that the measures you're tracking are documented appropriately. While other practices may be able to wait until the end of the year to make a final determination on which measures can and should be reported (if they're using Registries and have that freedom), the transient nature of the provider population makes this difficult at an AMC. Picking measures up front may be beneficial, but make sure you understand how your historical results compare to the CMS mean, first.

Clearly define roles for everyone in the practice to ensure that all appropriate action is taken, on both the clinical and administrative sides. Limit the period of time between provider orientation to your practice's system for PQRS and when he or she becomes a full-fledged participant.

Work with a Registry that is qualified to report on a wide measure pool. This gives you a distinct advantage. Since many AMCs are already engaged in other quality measurement initiatives (e.g. measures from private health plans, hospital-based programs), there may an opportunity to report similar PQRS measures. Having protocols in place to collect this information is half the battle, and aligning measurement across the system limits the amount of overhead that would otherwise be required for each separate program.

Organize your IT support to succeed in PQRS. Although a common Electronic Medical Record (EMR) is almost always distributed across the network, without appropriate IT and decision support, the EMR will be used differently across clinics, and even by providers in

the same clinic. But what's the big deal? If it's all in the EMR, then the AMC is covered, right? Wrong. When EMRs are used differently by people within the same organization, this severely impacts the system's ability to facilitate informed clinical decision making.

The High Cost of Inconsistent Data

The impact here is two-fold. First, by failing to collect the required information (or at least, collect it in a manner that lends itself to data sharing), simply reporting measures for PQRS becomes a challenge. Discovering there is only sporadic information for the measure you thought you were tracking for the last three months means that you need to spend all of your time focusing on documentation and filling in gaps, and less time actually trying to improve performance. This will put you at a disadvantage compared to those who have processes in place, and who are making that transition from focusing on reporting to performance.

The second issue is that, if your organization is not documenting consistently, any activity related to quality measurement or improvement is going to be fraught with inaccuracy or, at least, inconsistency. There is no way that you will be able to measure and improve if you cannot create a baseline of where you stand today. You may have invested a lot of time, resources and effort into a population health initiative, but how will you know if it worked?

Another problem with inconsistent data is that it breeds dissent among practices and providers. In order to improve from year to year, the AMC's quality department will need to investigate instances where performance was lower than expected, and that may lead to difficult conversations. These are sensitive topics, and without having reliable information, discussions can rapidly morph from productive to contentious.

In a Pay-for-Performance initiative, such as the Value-Based Payment Modifier, Academic Medical Centers have many advantages. AMCs have a wide range of specialties, giving them a greater selection of measures for reporting. Entire departments are dedicated to quality measurement and performance improvement, with resources for Population Health. However, AMCs also face unique challenges of maintaining consistent workflows across sites and identifying eligible providers. Departmental coordination, down to the last detail, is key both to managing workflow and pinning down an accurate roster of the providers who have (and are) contributing to measures. There's still time to demonstrate value-based care—you just need to start now.

Download your free copy of the ICLOPS *Insider's Guide to PQRS 2015 Reporting: How to Succeed in the Value-Based Health Care Environment.*

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