For the record
Qualified clinical data registries take the measure of data

By Mark Harris

This year marks the introduction of a new stage in the evolving world of Medicare payment reform. On October 14, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for the Medicare Access and CHIP (Children’s Health Insurance Program) Reauthorization Act of 2015 (MACRA). Under MACRA, performance measurements for new payment models began in 2017.1

What is the significance of MACRA? First, the new payment system replaces Medicare’s old sustainable growth rate (SGR) formula used to manage health care spending. Also, MACRA represents a move away from the traditional fee-for-service payment model toward a more value-based system designed to reward the quality of care provided over the quantity of services delivered. A crucial component of this drive toward value is Medicare’s new Quality Payment Program (QPP), which offers providers new tools and resources for promoting best care practices.1

Naturally, to improve the quality of care, physicians need knowledge of what treatments work and what ones do not. As Medicare moves toward more value-based reimbursement, one resource in the QPP tool kit will be the qualified clinical data registry (QCDR), a unique new reporting mechanism designed to enhance data collection in specialty areas of medicine. Medicare hopes QCDRs will become increasingly valued tools for medical specialty groups to identify and improve best practices in their respective fields of care.

The road to reform

Under MACRA, the QPP and resources such as the QCDR are not designed to be quick fixes in the payment system. In fact, experts say the transition from fee-for-service to more value-based models of care is reform long in the making.

“MACRA did not just come out of the blue in 2015,” remarks Pamela Ballou-Nelson, PhD, MSPH, RN, a senior consultant for the Medical Group Management Association (MGMA) based in Englewood, Colorado. “If you’re a historian of health care, you know we have been walking toward operationalizing value-based models of care for some time now. In fact, this transformation in our health care system began with the 1994 report from the Institute of Medicine (IOM), America’s Health in Transition: Protecting and Improving Quality.2 This was the first phase of the quality initiative when we began to document the pervasive nature of the nation’s overall health care quality problem. The conclusion at the time was that the burden of harm conveyed by the collective impact of our health care quality problem was staggering.”

Fast forward to 2017. Value-based care models oriented toward measuring and rewarding quality have become an all-stakeholder project, says Dr. Ballou-Nelson. These models are already making an
Logging on

Unfortunately, Medicare reimbursement issues can be incredibly complicated to understand, Stryker acknowledges. Indeed, one recent survey found widespread uncertainty among medical practices about the impact of payment reform and the requirements following the launch of MACRA. More than 40 percent of those surveyed acknowledged they were unsure if they understood how MACRA or the QPP works.  

So, where to start? What should health care providers know about the QPP and reporting resources such as the QCDR? First, there are two new payment tracks under the QPP in which providers can participate:

- Merit-Based Incentive Payment System (MIPS)
- Advanced Alternative Payment Models (APMs)

Starting in 2017, the QPP combines Medicare’s meaningful use (MU), Physician Quality Reporting System (PQRS), and Physician Value-Based Payment Modifier (VM) programs into one MIPS score to streamline reporting. Using this composite MIPS performance score, participating clinicians may receive either a payment bonus, penalty, or no payment adjustment.

Several health professionals are eligible to participate in MIPS:

- Physicians
- Nurse practitioners
- Physician assistants
- Clinical nurse specialists
- Certified registered nurse anesthetists

Eligible professionals can also participate either as individuals or as members of a group practice.

Notably, there are four reporting categories that contribute to the annual MIPS score:

1. Quality
2. Meaningful use of certified electronic health record technology (CEHRT), or advancing care information
   
   **Impact in Medicare’s new payment system**, and in the next few years that influence should expand to affect the world of commercial insurance as well, she notes.

   Indeed, as most industry observers acknowledge, on many issues Medicare tends to set the stage for what is to come throughout the health care system. “Where Medicare goes, the commercial payers are not far behind,” remarks Carol Stryker, MBA, a columnist for Physicians Practice and principal of Symbiotic Solutions in Houston. “The Medicare fee schedule is pretty much the baseline for everybody else. That’s why it’s really important to pay attention to what Medicare is doing.”

   SGR | Sustainable growth rate
The SGR formula was used to manage health care spending by Medicare on physician services

   Fee-for-service model of care
Physicians and other health care providers are paid for each service performed, such as tests and office visits.

   MACRA | Medicare Access and CHIP Reauthorization Act
MACRA establishes a new way to pay physicians who treat Medicare patients.

   Value-based model of care
Health care providers are rewarded with incentive payments for the quality of care they provide.

   QPP | Quality Payment Program
Offers two payment tracks:
- APMs | Advanced Alternative Payment Models
- MIPS | Merit-based Incentive Payment System

   QCDR | Qualified clinical data registry
Provides reporting mechanism to enhance data collection in specialty areas of medicine.
3. Clinical practice improvement activities (CPIA), or improvement activities

4. Resource use, or cost

Under this system, MIPS payment adjustments apply to Medicare Part B two years after the performance year for which data is collected. Thus, the data collected by individual clinicians and group practices in the performance year 2017 will be applied to payment adjustments in 2019. As part of the first-year program rollout, the cost category will be calculated for 2017 but not used to determine any payment adjustments until 2018.5

The reporting options under the quality category, which constitutes more than half the composite score, are basically the same as under the older PQRS, which is now being phased out. For both individual clinicians and groups, these include the option to report using a qualified registry, electronic health record (EHR), QCDR, or through claims processing. Group participants can also report through a Web interface or a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.5

The other track for participation is that of the APMs. Providers who participate in an Advanced APM through Medicare Part B will earn incentive payments for their participation. As such, providers who in 2017 receive 25 percent of their Medicare payments or see 20 percent of Medicare patients through an Advanced APM can expect to earn a 5 percent incentive payment in 2019.4

The more complex Advanced APM track is designed for practices making more concerted efforts to improve patient care and take on risk related to their patients’ outcomes.7 An Advanced APM can apply to specific clinical conditions, a care episode, or a population.7 At this early juncture in the QPP, approximately 85 percent of eligible professionals are expected to choose the MIPS route over the APM track, says Dr. Richardson.

Measure up

This is where the QCDR enters the picture. As a component of these larger payment reforms, the QCDR is designed to help clinicians enhance their data collection methods and analytics to promote more patient-centered, cost-sensitive quality care. Typically, the QCDR is organized through a specialty society, certification board, or regional health collaborative. Notably, QCDRs are distinct from other qualified registries in that participants have the option to report both MIPS and non-MIPS performance measures.8,9

For many industry observers, the QCDR model offers the promise of both a more streamlined reporting system and enhanced data analysis. “The challenge is to coordinate care across the continuum so that we have fewer mistakes, better outcomes, and avoid the duplication [of services] and costly procedures that can happen when providers are not coordinating care,” says Dr. Ballou-Nelson. “With a QCDR that can focus in on geographic data, or certain disease entities and outcomes, we can begin to better piece together what are our best practices. This is the promise of QCDRs as we move forward to a transformed health care system.”

In an interview for ReachMD, a podcast series from the American Medical Association (AMA), Koryn Rubin, the assistant director of federal affairs at AMA, notes that QCDR use is “heavily incentivized and encouraged” within the QPP. “CMS provides several ways for physicians to utilize a QCDR to satisfy the QPP,” says Rubin. “Primarily where you would receive the most credit for satisfying requirements is through the quality category, so a physician or practice can meet the quality category by utilizing a QCDR to report on quality measures. You also can receive credit, and depending on the activities you choose, you can satisfy all the improvement category requirements. You also can receive some bonus points in [the] advancing care information category if you report the optional clinical data registry measure, and you would do that by utilizing a QCDR.”10

What’s a QCDR?

A qualified clinical data registry (QCDR) is an entity that collects clinical data on behalf of clinicians for data submission and is approved by the Centers for Medicare & Medicaid Services (CMS). Examples include, but are not limited to, regional collaboratives and specialty societies. Also, QCDRs cannot be owned or managed by an individual, locally owned, specialty group.8

The QCDR reporting option is different from a qualified registry because it is not limited to measures within the Quality Payment Program (QPP). The QCDR can host CMS-approved, non-Merit-Based Incentive Payment System (MIPS) measures for reporting. A QCDR may submit measures from one or more of the following categories, with a maximum of 30 non-MIPS measures allowed per QCDR:9

- Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS), which must be reported via a CAHPS-certified vendor
- National Quality Forum (NQF) endorsed measures
- Current 2017 MIPS measures
- Measures used by boards or specialty societies
- Measures used by regional quality collaborations
- Other approved CMS measures

There are other significant changes in the transition to QCDR use, reports Rubin. As noted, the PQRS program for quality reporting now transitions into the QPP, while Medicare has also lowered the reporting requirements from nine to six measures. Notably, among the six measures, one is expected to be an outcome measure.10
A painless process

One group using a QCDR is the American Society of Anesthesiologists (ASA). The ASA-affiliated Anesthesia Quality Institute (AQI) sponsors the National Anesthesia Clinical Outcomes Registry (NACOR), a CMS-approved QCDR in this specialty area.\(^{11}\)

The Anesthesiology Specialty-Specific Measure Set identifies nine CMS-approved MIPS measures, including the following\(^ {12} \):

- Documenting current medications in the medical record
- Preventive care and screening for high blood pressure and follow-up
- Anesthesiology smoking abstinence
- Perioperative temperature management

Participants in the QCDR can also select measures from the broader, nonspecialty set of MIPS measures.\(^ {12} \)

If fewer than six measures apply to a clinician, the clinician should then report on all applicable measures, including one outcome measure, according to the instructions for NACOR participants from ASA. In the absence of the latter, clinicians must report a high priority measure, which applies to such categories as the following\(^ {12} \):

- Appropriate use
- Patient safety
- Efficiency
- Patient experience
- Care coordination

Clinicians must also report on at least 50 percent of their patients to whom the measure applies for all payers (Medicare and non-Medicare).

For quality measurement experts, the use of QCDRs in specialty areas, such as anesthesiology, is a promising development. “In the coming years, QCDRs will be allowed to define specific CPIAs [clinical practice improvement activities] for clinicians or groups through an established approval process,” says Emily Richardson, MD, an anesthesiologist and chief quality officer of Encompass Medical Partners in Fort Collins, Colorado, in a commentary written just prior to adoption of MACRA’s final rule. “Additional measures and activities captured by QCDRs could enable specialty clinicians or groups to capture and report on more meaningful activities. In the proposed rule, CMS describes a call for measures and activities processes where MIPS-eligible clinicians, groups, and other stakeholders may recommend activities for potential inclusion in the CPIA Inventory. The use of QCDRs also allows for ongoing performance feedback and the implementation of continuous process improvements, ultimately enabling us to reach our goal of providing better patient care.”\(^ {11} \)

The measurement process itself can facilitate a more engaged and productive quality improvement culture, notes Dr. Richardson, who is also chairperson of the Practice Quality Improvement Committee for the AQI. As an example, she cites the impact of the specialty-specific MIPS measure for perioperative temperature management in anesthesiology.

“It is well known in anesthesia and surgery that when patients get cold they are more likely to have complications,” observes Dr. Richardson. “This is because when people are under anesthesia they essentially lose heat very rapidly. And when they become cold, there are physiologic changes that can occur. . . . That’s why it makes sense for anesthesiologists to measure how we are doing at keeping the patient warm.”

With the QCDR, physicians are better able to measure how patients are doing under different providers, says Dr. Richardson. “Interestingly, the first iteration of the measure for temperature management asked whether the patient was warm at the end of the case or in the recovery room. If they were, wonderful. If they weren’t, then the question became: Did you at least try to warm them? If you tried to warm them, but they were still cold, you still kind of ‘passed.’ But last year this measure was changed,”

“If there are no outcome measures within that QCDR, then you would report on high-priority measures,” says Rubin. “CMS defines a high-priority measure as a measure that covers appropriate use, patient safety, care coordination, or patient experience. Also, if you’re going for or trying to obtain an incentive when you report in 2017 and not just avoid a penalty, the measures that you report on must be reported on 50 percent of applicable patients.”\(^ {10} \)
she points out. “That get-out-of-jail-free card—’I tried to warm them’—was essentially taken away. Now, that’s no longer good enough. Instead, there is an actual outcome measure that asks: Was the patient warm, yes or no? And if they weren’t warm, was there some medical reason to explain why? If not, then that’s a poor score.”

Often, Dr. Richardson notes, behaviors also change when physicians know they are being measured. “With temperature management five years ago, someone might have said, ‘Well, my patient’s cold. I tried, [but] so what?’ Now, they’re more likely to say, ‘Gosh, they’re cold. I’ll see if I can warm them up by the end of this case.’”

More generally, measurement activities can prompt clinicians to become better focused on how they are doing and to think more critically about what constitutes best practices in their work. As Dr. Richardson notes, “When you talk to individual clinicians, they often don’t necessarily see any problems with their work. They think they’re doing great. But with better data and analytics, I think the first thing we’re going to see is that we actually do have some deficiencies. This should help providers open their eyes a little more. Once we have the sophistication with registries, we’re going to be better able to say, ‘OK, we found a deficiency, we’re not particularly good at this type of measure, and now we have an opportunity to improve.’”

**Body of research**

Another informative example of a QCDR in operation is the Diabetes Collaborative Registry. The registry represents a unique interdisciplinary data-gathering initiative led by several entities, including the following:

- The American College of Cardiology
- The American Diabetes Association
- The American College of Physicians
to interpret benchmark reports that validate participating providers.

Additional data for cardiovascular disease, and cardiometabolic measures and metrics for diabetes, cardiology, and other providers treating primary care physicians, endocrinologists, and other providers treating diabetes patients. The Diabetes Collaborative Registry collects data from primary care physicians, endocrinologists, cardiologists, and other providers treating diabetes patients. As the first initiative to gather key clinical data across multiple specialty areas, industry observers are hopeful about the registry’s future impact on diabetes care. “The Diabetes Collaborative Registry is a real-world collaboration that looks at diabetes across specialty and primary care lines,” says Dr. Ballou-Nelson. “In my view, it’s a great example of how we can establish our best practices. When we can state that 3,000 physicians do it this way and this is the outcome, any physician will then be able to ask: How do I benchmark and compare with these practices?”

Dr. Ballou-Nelson is particularly hopeful the enhanced knowledge made available through QCDR registries will increasingly resonate with physicians. “The advantage of the QCDR is that it integrates improvement activity, technology, and best practices for a particular type of condition or entity with outcomes and costs. I think physicians will recognize and identify with QCDRs much more quickly and see the big picture more completely since they’re not just looking at isolated quality measures.”

Indeed, the potential of the QCDR is essentially found in the greater meaning it can bring to physicians about the data they collect and the work they do, says Dr. Ballou-Nelson. As an example of this, she shares an observation from her recent consulting work for MGMA.

“I was working with a group of endocrinology specialists who were not very interested in Medicare’s meaningful use program or the Physician Quality Reporting System [PQRS],” she says. “They participated in these programs, but didn’t really see the bigger picture. Then along came MACRA’s QPP.

“Initially, they were even less interested, and even a little bummed out, about what they thought they were now going to have to do. But then, lo and behold, one of the physicians read an article about the Diabetes Collaborative Registry as the first global, cross-specialty, clinical registry designed to track and improve the quality of diabetes and metabolic care across the primary care and specialty care continuum,” she continues.

“Well, all of a sudden, this physician group had interest. They saw that these were physicians putting this collaborative registry together, that they were talking about integrating care and the health of the [patient] population across the continuum. They now understood that this is what the QPP is all about,” she explains. “This physician group hadn’t been able to make sense out of the individual quality measures, but the Diabetes Collaborative Registry put the whole issue together. Thanks to the registry, it made sense to them.”

Medicare made easier

To many observers, Medicare’s payment system appears to be an imposing labyrinth of regulations, requirements, and programs. Admittedly, this is not always an unfair perception. To introduce major changes into such a complex system might understandably stir up even more anxiety or uncertainty among providers concerned with keeping their footing on Medicare’s shifting payment landscapes.

But Medicare’s payment reforms are not intended to further complicate life for providers or patients. In fact, one goal of
MACRA and the QPP is to establish a more streamlined and meaningful user experience, one that offers providers more flexible options in how they may choose to participate. In this spirit, CMS has made available four flexible first-year reporting options for 2017 to help ease clinicians’ transition into the new payment system.16 Meanwhile, QCDR use is expected to expand. As of late 2016, some reports indicate approximately 70 QCDRs are now in various stages of development.10

While the MACRA-initiated QPP in all its parts is complex, Dr. Richardson says CMS has spent considerable time listening to the provider community’s concerns to make the program less burdensome. “The QPP is a tough program to understand, but I think when we’re able to present it in a straightforward way clinicians can see that it’s actually doable,” she says. “I won’t say it is less complex than the earlier programs, but CMS has at least tried to align the reporting methods with the goals of what’s important to providers.”

Accordingly, Dr. Richardson is also optimistic that as QCDRs become more established, the resulting enhanced data collection will be increasingly helpful to clinicians. “Ideally, the goal is to have valid, robust registry data that physicians can use to improve the care they deliver,” she says. “The nice thing about QCDRs is that providers can now essentially report their data to one place. There is also much more flexibility. Unlike the qualified registries, QCDRs are not limited to MIPS measures. We also have more measures to choose from.

“Of course, it’s still a work in progress,” notes Dr. Richardson. “The registries are still growing. There remain difficulties in the vendor world, in terms of making registries useful and functional for clinicians. So, yes, we do need to have good registries and good ways to collect data. We need to have accurate reporting systems. Again, these are all in a growing phase. But once we have that infrastructure in place . . . I think we’ll have a wonderful resource to identify problems and improve care.”

For now, clinicians, practice managers, and other professionals involved in data collection should take the time to familiarize themselves with the basics of how the QPP works. “Quality reporting is certainly not going away,” cautions Stryker. “But managers should know these programs are not always as hard to implement as they seem to be. It’s just important that whoever is responsible for making it happen in the practice gets a good foundational understanding of what Medicare, and by extension, the other [insurance] carriers, are trying to accomplish. To the extent possible, my advice is to go to the primary sources. Study the Medicare website, [and] read and pay attention to the details. You can also ask your billing companies to help. It’s to their advantage for a practice to be compliant with quality requirements and quality reporting measures.”

All in all, the QPP and the QCDR reporting model represent a long-term opportunity to enhance data collection toward the goal of establishing more consistent best practices. “Our goal now is to begin to try to better standardize our care,” concludes Dr. Ballou-Nelson. “In the past, we have not done a good job in identifying best practices in mapping care across the continuum. This is because we really haven’t had that integrated data to be able to say this is working [and] this is not working. We need current integrated data to do that. This is the beauty of the QCDR.”

References
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