

## **Why MSSP ACOs Should Partner with an Experienced Quality Reporting Vendor**

In our previous guide, we walked through the six essential steps of MSSP ACO eCQM reporting. Understanding this process makes you an informed partner and ensures you maintain strategic oversight of your quality program.

But here's what we've learned: knowing how something works is fundamentally different from being responsible for making it work, year after year, without failure. You probably understand how quality reporting works conceptually—that knowledge makes you an informed healthcare leader. It doesn't mean you should self-report for your ACO.

## **Ongoing CMS Quality Reporting Requirements and Technical Challenges**

CMS reporting requirements don't stand still. Rules governing MIPS, APP, Medicare CQM, and eCQM reporting change every year. CQL specifications get updated. QRDA file structures change. FHIR requirements become more complex as CMS pushes toward fully digital quality measurement.

Each change requires someone to interpret new requirements, modify data extraction logic, update validation rules, and rebuild submission file generators. This isn't a project with an end—it's an ongoing operational commitment demanding specialized expertise.

The technical specifications are extraordinarily detailed. A single misplaced XML tag in a QRDA-III file triggers submission rejection. Misinterpreted measure logic lowers quality scores. Small mistakes have outsized consequences, and CMS keeps moving the target.

## **Hidden Costs of Building and Maintaining Infrastructure for Self-Reporting**

The full infrastructure requirements run far deeper than most ACOs realize. You need data integration tools connecting to multiple EHRs—common in multi-TIN ACOs. You need validation systems for QRDA-I and QRDA-III files. You need data quality checks catching missing fields and documentation gaps. You need de-duplication logic identifying when the same patient appears in multiple practices.

Building this requires a dedicated IT and data team—not part-time staff, but dedicated professionals who understand healthcare data, CMS specifications, and clinical quality measures. Hosting costs alone—cloud infrastructure and data pipelines—run into thousands of dollars annually.

Vendors spread these costs across multiple ACOs, making the economics work at scale. Building for just one organization changes the return on investment dramatically.

## **CMS Audit-Readiness Demands QRDA Documentation and Data Lineages**

CMS audits require comprehensive documentation showing exactly how you calculated every measure—complete data lineage from EHR extraction through every transformation and validation check to final submission.

You need patient-level drill-downs showing precisely why each patient appeared in each measure. You need chart validation workflows proving electronic data reflects actual clinical documentation. You need to document every data transformation decision.

Without this traceable audit trail, you risk losing shared savings if CMS questions your data. Experienced vendors, like MRO, ensure audit readiness is baked into their service—they maintain documentation infrastructure, patient-level drill-downs, and chart validation workflows.

### **EHR Data Quality Challenges in Multi-TIN ACO Reporting**

ACOs often underestimate the messiness of EHR data. Providers use retired codes that no longer map to current requirements. Vitals get recorded in free text instead of structured fields—a blood pressure reading buried in a clinical note can't calculate the "Controlling High Blood Pressure" measure. Lab results from external facilities never make it into the EHR record. Multiple EHR systems structure data differently.

Vendors have refinement and normalization engines specifically built to handle this chaos. They've seen countless variations of critical data, different documentation methods, and each EHR vendor's unique formatting.

Here's the unfortunate part: ACOs doing this themselves often underperform not because care quality is poor, but because data capture is incomplete. The care happened. The documentation exists. But the structured data needed for reporting? Missing, inconsistent, or trapped in formats the measure calculation engine can't process.

### **How a Vendor Partner Reduces Practice Burden**

Self-reporting doesn't just affect your central operations—the burden radiates to every participating practice. Practices get asked to export QRDA files, upload to portals, and respond to validation requests. These practices are already stretched thin. Every hour spent on quality reporting isn't spent seeing patients or improving care delivery.

This creates friction, delays, and incomplete submissions. Vendors offer practice-facing teams who provide proactive, hands-on support—they become the single point of contact for technical questions, file uploads, and validation requests, freeing ACO staff to focus on care delivery.

### **What is the Opportunity Cost of eCQM Reporting Infrastructure Investment**

Money spent building eCQM reporting infrastructure could instead be invested in something that actually improves patient outcomes. You could hire care coordinators for high-risk patients. You could build chronic disease management programs. You could implement patient outreach for overdue preventive screenings.

These investments generate measurable returns—improved quality scores, reduced hospitalizations, higher shared savings. Building eCQM reporting infrastructure generates no such returns. It's solely a compliance cost—essential but not differentiating.

Outsourcing reporting allows ACO leadership to focus on strategy and growth, not compliance plumbing, and invest in activities that actually distinguish your ACO.

### **The Performance Benchmarks and Insights You'll Miss**

When you self-report, you see only your own performance. You know your diabetes control rate is 82%—but is that good? How does it compare to CMS benchmark thresholds? To other ACOs? To national averages?

Vendors benchmark your measures against CMS thresholds, other ACOs in their network, and national averages. This context transforms raw data into clinical intelligence—you discover not just where you stand, but where specific opportunities exist to close gaps and maximize performance.

Without these insights, ACOs miss opportunities to identify problems early. You discover gaps too late to intervene and lose shared savings because you lacked comparative data showing you were underperforming.

### **Build vs. Buy: The Case for Partnering with a Quality Reporting Vendor**

Self-reporting seems cheaper upfront, but the real calculation includes audit risk, infrastructure costs, opportunity costs, and the possibility of lower quality scores due to data quality issues or submission errors.

Partnering with a vendor ensures compliance, scalability, and actionable insights while reducing administrative burden on practices and providers. Understanding how eCQM reporting works—what you learned in our DIY guide—makes you a sophisticated buyer who can evaluate vendors critically and hold partners accountable.

But being sophisticated doesn't mean doing everything yourself. It means knowing when to build and when to buy and focusing limited resources on activities that matter most. Still deciding on your best move? Download our ACO Self-Reporting Readiness Checklist and make a calculated decision.

ACO Self-Reporting Readiness Checklist

At MRO, our comprehensive quality reporting platform handles the technical complexity—multi-EHR data aggregation, validation, QRDA-III generation, and submissions. We provide benchmarking insights, practice engagement support, and audit-readiness, so you can focus on improving patient care and maximizing the value you deliver to your practices.

**Contact MRO today to learn how we can become your strategic partner in quality reporting.**