PQRI Feedback Spurs Improvements for 2009

BY ALICIA AULT
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WASHINGTON — Data from the first 6 months of the Physician Quality Reporting Initiative (PQRI) are spurring improvements for the upcoming year, a Medicare official testified at a meeting of the Practicing Physicians Advisory Council.

In the summer of 2008, the CMS paid $36 million in bonuses to 56,000 physicians for their 2007 reporting, said Dr. Michael T. Rapp, director of the quality measurement and health assessment group at the Centers for Medicare and Medicaid Services. The average payment was $600 for 6 months' of data; for 2008 reports, the 1.5% bonus is likely to be around $800 on average, he said.

There will be a number of changes for reporting in 2009. In all, there will be 153 reportable measures. Fifty-two are new, and 18 are reportable only through registries. There are seven measures groups: diabetes mellitus, chronic kidney disease, preventive care, coronary artery bypass graft surgery, rheumatoid arthritis, perioperative care, and back pain. Each group contains a number of measures; physicians can report these only as groups.

There will be nine different ways physicians can qualify for the 2% PQRI bonus in 2009, said Dr. Rapp. Physicians also can receive an additional 2% bonus for satisfying requirements under the separate e-prescribing incentive program.

Under last year's Medicare Improvements for Patients and Providers Act, the CMS is required to eventually post on its Web site the names of physicians who satisfactorily report quality measures for 2009. That proposal has been controversial.

PPAC panelist Dr. Frederica Smith, an internist and rheumatologist in Albuquerque, N.M., called the idea a "terrifying concept," given that it might appear that physicians who were not on the list did not care about quality.

And physicians had many problems complying with the CMS process for reporting measures in 2007, she noted.

Dr. Rapp agreed that the first phase of the program had been frustrating. But "the way it was for 2007 doesn't mean that's the way it will be for 2008," he said. The agency has posted a detailed report on the 2007 experience at its Web site (www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportExperience.pdf).

Overall, there were submissions from 109,349 national provider identifier/tax identification numbers with at least one quality data code. Of those, about 93% (101,138) submitted at least one valid code. More than 14 million codes were reported; more than 50% of those (7.3 million) were validly submitted.

There were three major reasons for code nonvalidity: The provider did not adhere to the measure specification; the codes were not submitted with the same claim as the billing and diagnosis code submitted for the procedure; or there was no national provider identification (NPI) number on the claim.

Many of the submission errors were for patients who did not meet the reporting specifications regarding gender, age, or diagnosis or procedure code for a particular measure. For instance, the PQRI does not accept reports for diabetes measures on patients over age 75, said Dr. Rapp.

He said that the CMS plans to rerun reports for providers who did not qualify for the bonus, with the idea that mistakes could have been made and some providers could be found eligible for the bonus on reanalysis. If that is the case, the CMS will issue checks retroactively, he said.

The agency also aims to make some changes that will hopefully reduce the number of rejected reports going forward. The CMS said that it would continue to conduct provider education and outreach to make sure that physicians understand the specifications for reporting each measure.

The agency also is working with local Medicare carriers to ensure that when claims get split—where the quality codes are separated—they will be "reconnected and counted," according to the agency.

Also, claims that were submitted to carriers for payment in 2008 without an NPI were automatically rejected. As a result, in the first half of 2008, less than 1% of claims submitted under the PQRI program were missing an NPI, according to the agency's report. The CMS expects less than 0.5% of PQRI claims to be without an NPI.

Dr. Rapp said that the agency would make it easier to get PQRI reports for 2008 and that they would be more meaningful to providers. The feedback reports are being redesigned and will better explain what percentage of quality codes are accepted, indicate why the provider did not earn an incentive, and provide information on how well they performed on each measure.

The PPAC panel recommended that the CMS find a way to make the quality reports available to physicians on a real-time basis so that they can perform more timely adjustments of their data collection and reporting. ■

Some See Health Reform Gathering Momentum Early

BY MARY ELLEN SCHNEIDER
New York Bureau

Early signals from the incoming Obama administration have many physicians feeling optimistic about the chances for comprehensive health reform.

The economy is one reason that health reform may have a greater chance for success now than it did during the Clinton administration, said Dr. Nancy H. Nielsen, president of the American Medical Association. As more Americans lose their jobs, they are also losing their health insurance, she said, driving policy makers to address the issue of the uninsured. "There may be more tension for change now than there has been in the past," she said.

President-elect Barack Obama addressed that tension head-on during a press conference last month to announce former Sen. Tom Daschle (D-S.D.) as his choice for Health and Human Services secretary.

The current state of health care in the United States—with rising premiums and the large number of uninsured Americans—is having a direct and negative impact on the U.S. economy, President-elect Obama said. "If we want to overcome our economic challenges, we must also finally address our health care challenge."

In a move that many agree signals how serious Mr. Obama is about health reform, he tapped Sen. Daschle for not one, but two posts. In addition to serving as HHS secretary, Sen. Daschle is slated to serve as director for a new White House Office on Health Care Reform. Jeanne M. Lambrew, Ph.D., a health policy expert who coauthored the health care book "Critical: What We Can Do About the Health-Care Crisis" with Sen. Daschle, was chosen as deputy director of the new White House office.

Sen. Daschle's HHS position must be confirmed by the Senate; however, the health care czar position does not.

In another example of his focus on health care reform, Mr. Obama, along with congressional Democrats, have signaled their interest in including health information technology incentives as part of an economic stimulus package, said Robert Doherty, senior vice president of Governmental Affairs and Public Policy at the American College of Physicians. "I think the signals are positive."

The Obama transition team appears to be learning from some of the mistakes made during the Clinton administration's attempt at health reform, Mr. Doherty said. For instance, there has been a much greater effort by the Obama staff members to be open about their process and to gather input from the physician community.

Physician societies are making their priorities known to the new administration, emphasizing the need for physician payment reform to be a part of any reform package.

The AMA is pushing Congress and the administration to enact permanent Medicare physician payment reform by eliminating the Sustainable Growth Rate formula, which ties physician payments to the gross domestic product. Without congressional action on the payment formula within the next year, physicians will be faced with a projected 21% cut in Medicare payments starting in 2010, Dr. Nielsen said.

If Congress chooses to throw out the SGR formula, they likely will need to authorize some fast-track pilot projects to test some of the most promising models for new payment systems such as global and bundled payments, said ACP's Mr. Doherty.

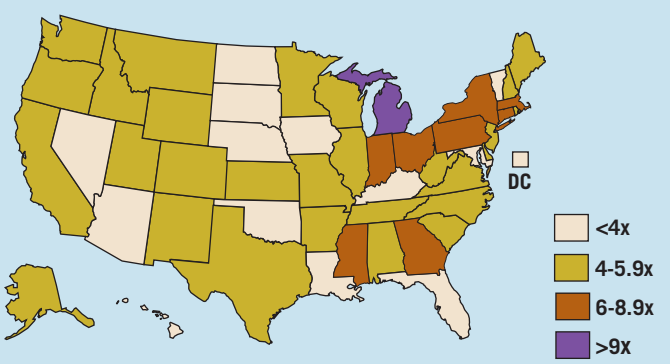
ACP officials are hoping that the Obama health reform proposal will include some of their top priorities—coverage of the uninsured and improving access to primary care physicians. The experience with the Massachusetts health reform law illustrates that expanding insurance coverage does not guarantee access to care if there are not enough primary care physicians to see all the new patients, Mr. Doherty said.

Shoring up the primary care workforce will require an increase in payments for primary care services, an emphasis on primary care in graduate medical education funding, and the creation of programs that would allow primary care physicians to eliminate their medical school debt, he said.

The American College of Cardiology did not respond to requests about its legislative goals for 2009. ■

DATA WATCH

Health Premiums in Michigan Rose 17 Times Faster Than Median Earnings From 2000 to 2007



Note: Based on data from the U.S. Census Bureau, the Department of Labor, and the Department of Health and Human Services.
Source: Families USA