Medicare Changes Quality Reporting Initiative

BY MARY ELLEN SCHNEIDER
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Physicians now have nine different options for submitting quality data to Medicare under the Physician Quality Reporting Initiative.

The new options include three ways to submit claims-based data and six registry-based methods for reporting (see box). For example, physicians will have the option of reporting data on groups of related clinical measures or individual measures and they can report for a full or half year. Officials at the Centers for Medicare and Medicaid Services announced the changes last month.

Under the Physician Quality Reporting Initiative (PQRI), launched last July, physicians can earn up to a 1.5% bonus on all of their total allowed Medicare charges for covered services for reporting on certain quality measures to CMS.

"We are encouraged by the success of the program so far, and with the new options for data reporting, more health professionals should take advantage of the reporting system," CMS Acting Administrator Kerry Weems said in a statement.

In the meantime, physicians who reported data in 2007 are still waiting for their bonus checks and feedback on their performance. CMS accepted 2007 data until the end of February and is currently analyzing the information. CMS officials expect to provide results and bonus payments to physicians in mid-July.

Preliminary data show that in 2007, more than 100,000 physicians and other eligible professionals submitted quality data at least once to the voluntary reporting program. CMS estimates that about half of those who participated in 2007 will receive an incentive payment.

In 2007, CMS officials selected 74 quality measures to be used across various specialties. If three or more measures applied, physicians had to report on at least three measures for at least 80% of applicable patients. If fewer than three measures were applicable, physicians had to report on each measure for at least 80% of the eligible patients. All reporting was claims based and covered the period from July 1 to Dec. 31, 2007.

This year, CMS has expanded the list of measures to 119, with 117 clinical measures and 2 structural measures. The structural measures relate to e-prescribing and electronic health record adoption and use.

CMS will also allow physicians to report on their clinical interactions for a full year from Jan. 1 to Dec. 31, 2008, or a half-year starting on July 1. Those physicians who haven't started reporting yet should still consider the full-year option, Dr. Michael T. Rapp, director of the quality measurement and health assessment group at CMS, said during a CMS-sponsored provider call on PQRI. Because 60 of the measures require only once-a-year reporting, physicians could still meet the 80% threshold if they started in May or June, he said.

CMS is also allowing providers to report either individual measures or "measures groups." CMS has created four measures groups with at least four measures each. The groups include diabetes, end-stage renal disease, chronic kidney disease, and preventive care.

For example, the end-stage renal disease group includes four measures: vascular access for hemodialysis patients, influenza vaccination, plan of care for patients with anemia, and plan of care for inadequate hemodialysis. In order to qualify for payment using measures groups, physicians have to submit data for each of the measures in the group. Eligible professionals will also be able to report to clinical registries instead of submitting claims directly to CMS. Physicians would report data to the registry, which would in turn report to CMS.

Currently, CMS is testing submission from registries and plans to publish a list of qualified registries in late August.

Despite the late announcement of qualified registries, physicians can still consider full-year participation with this option, Dr. Rapp said, because data are often submitted to registries months after the clinical encounter has occurred.

However, more details will be needed on registry-based reporting, said Brian Whitman, who monitors regulatory and insurer affairs at the American College of Physicians. Another unanswered question is how CMS will ensure that the data being submitted by registries is accurate, Mr. Whitman said. ■

More information about the different reporting options is available online at www.cms.hhs.gov/pqri.

Here are Nine Physician Quality Reporting Options

The Centers for Medicare and Medicaid Services outlined nine options for reporting data to PQRI in 2008.

Three options allow claims-based reporting:

► Physicians can choose to report on individual measures for the full year of 2008. Under this option, physicians with three or more applicable measures would report on at least three measures for at least 80% of their patients. Those with fewer than three applicable measures would report on all of those measures for at least 80% of their eligible patients.

► Physicians can also choose from two reporting approaches for the half-year reporting period from July 1 to Dec. 31. Physicians could report on all measures in a measures group for 15 consecutive patients with the relevant condition or 80% of eligible patients.

Six options are registry-based:

► CMS will allow three reporting options for a full-year reporting period. Those who chose to report on individual measures must report on 80% of applicable cases for a minimum of three measures. Physicians can also report on a measures group for 30 consecutive patients with the applicable condition or 80% of the applicable cases.

► CMS has also established three reporting options for reporting to a registry for a half-year from July 1 to Dec. 31. For example, physicians and other eligible professionals could report on individual measures for 80% of applicable cases for a minimum of three measures. Physicians could also report for a half-year using measures groups. For example, physicians can report on a measures group for 15 consecutive patients with the applicable condition or 80% of applicable cases.

Hospice Spending Tripled From 2000 to 2007, Stays Lengthened

BY ALICIA AULT
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WASHINGTON — Staggering growth in the popularity of hospice services—and in the rise of for-profit hospice providers—has caught the attention of the Medicare Payment Assessment Commission.

At their recent meeting, MedPAC commissioners debated the potential impact of rising hospice costs on the Medicare program. The hospice benefit began in 1983 with the idea that it would cost Medicare less to provide hospice than conventional end-of-life treatment, which is usually delivered in the hospital, said MedPAC staff member James Mathews, Ph.D.

But there is some evidence indicating that hospice use may actually result in higher spending, said Dr. Mathews.

According to MedPAC's analysis of Medicare claims data, hospice spending tripled from 2000 to 2007, when Medicare spent $10 billion on hospice services. The mean length of hospice stay increased 30% from 2000 to 2005. It's not clear why length of stay is increasing, although data have shown that some illnesses—such as Alzheimer's disease and ischemic heart disease—tend to result in longer stays, said Dr. Mathews.

One explanation may be that hospice care tends to be more expensive at the beginning and the end of the service; interim days are more profitable, so there is an incentive to lengthen stay, Dr. Mathews said.

But it appears that much of the growth in costs and length of stay is due to the huge increase in for-profit hospice facilities in the market.

Hospice facilities are worried that the CMS or Congress might clamp down on the 'huge growth spurt' that has been seen in the hospice field.

From 2000 to 2007, very few nonprofit hospices entered the market, while the for-profit sector grew 12% a year, Dr. Mathews said. There were a little more than 1,600 for-profit hospices in 2007, compared with about 1,200 nonprofit and 400 government-run facilities, according to the MedPAC analysis.

In addition, the analysis determined that profit margins are also much higher at for-profit hospice facilities. In 2005, the last year in the analysis, for-profit margins were about 12%, while nonprofits had negative margins. MedPAC also found that hospices that entered the market since 2000 had higher margins—and these were mostly for-profit operations.

Some hospices, only about 9%, are subject to a cap that limits the length of stay, but even those facilities have found a way to profit from Medicare, said Dr. Mathews.

"Clearly, people see an opportunity—a financial opportunity—here," commented MedPAC chairman Glenn Hackbarth, a health care consultant based in Bend, Ore. He said that the commission needed to find a way to keep the hospice program from spiraling out of control.

Commissioner Jack Ebeler suggested that Medicare "may need blunter instruments for slowing the growth," but also added that the health program should not do anything to lose "an extraordinarily valuable benefit."

MedPAC vice chairman Robert Reischauer, Ph.D., suggested that Medicare payment could be refined to buy more appropriate care.

"It strikes me that there's probably an easy way to do this," said Dr. Reischauer, who is also president of the Urban Institute.

J. Donald Schumacher, Psy.D., president and CEO of the National Hospice and Palliative Care Association, acknowledged that there has been a "huge growth spurt" in the hospice field. Facilities are worried that the Centers for Medicare and Medicaid Services or Congress might clamp down, using a "blunt instrument," Dr. Schumacher said at the meeting.

The commissioners and Dr. Schumacher agreed that a first step to a solution is collecting more data on the hospice sector.

CMS has already started down that path. In July, hospices will begin submitting data to CMS on the types of services they provide and which practitioners are delivering them. ■