Medicare Adds Quality Data Reporting Options

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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 quality for payment using measures groups, physicians have to submit data for each of the measures in the group.

Submitting Data Under PQRI

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

Three options facilitate claims-based reporting:

- Physicians can choose to report on individual measures for a full year from Jan. 1 to Dec. 31, 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.

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.

It appears that the changes will make it easier to report data, said Dr. James King, president of the American Academy of Family Physicians. "We want to be able to get our data in."

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. The extent to which internists will be able to use registry-based reporting will be unclear until CMS releases the list of participating registries in late August, he said. ■

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

Hospitalizations for Kidney Disease Up Sharply, CDC Reports

BY DIANA MAHONEY
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The rate of hospitalizations for kidney disease has risen sharply over the past 25 years, and the elevation has been driven primarily by a significant increase in the proportion of hospitalizations associated with acute renal failure relative to chronic kidney disease, particularly among older Americans, according to the Centers for Disease Control and Prevention.

An analysis of data from a national probability survey showed that the number of patients hospitalized with a diagnosis of either chronic or acute kidney disease rose from 416,000 in 1980 to 1.6 million in 2005, reported Dr. Nicole T. Flowers, a medical epidemiologist at the CDC, and her colleagues. Consistent increases in the rate of acute renal failure over the 25-year period, with smaller increases in the rate of chronic kidney failure, led to the shift in type of kidney disease most commonly associated with hospitalizations. The age-adjusted rate per 10,000 population for hospitalization for acute renal failure increased from 1.8 in 1980 to 36.5 in 2005. During the same period, the rate of chronic kidney failure rose from 7.4 to 13.8 per 10,000 population, they wrote (MMWR 2008;57:309-12).

Over a 25-year period, the hospitalization rates were up in all age groups except those under 18, and were 30%-40% higher among men than women.

Other trends emerging from the National Hospital Discharge Survey for 1980-2005 include consistently higher kidney disease hospitalization rates among men compared with women, a rise in the number of patients aged 65 years and older requiring hospitalization for kidney disease, and an increase in the number of kidney disease hospital discharges associated with a concomitant diagnosis of diabetes mellitus or hypertension.

Although the rates of kidney disease for both sexes increased significantly over the 25-year period, "the rates were consistently 30%-40% higher among men than among women," the authors reported. Hospitalizations increased in all age groups except for individuals younger than 18 years, they wrote, noting: "An increase of approximately 300% (from 56.2 to 179.3 per 10,000 population) occurred among persons aged 65-74 years, and an increase of approximately 350% (from 119.0 to 393.2 per 10,000 population) occurred among persons aged 75 years and older."

With respect to concomitant diagnoses, diabetes mellitus was reported as an additional discharge diagnosis for 23.4% of hospitalized kidney disease patients in 1980 and for 27.0% in 2005.

"This proportion peaked at 39.0% in 1996," the authors wrote. The percentage of hospitalized kidney disease patients with a discharge diagnosis of hypertension rose from 19.6% in 1980 to 41.1% in 2005.

In an accompanying editorial, the CDC suggested that the unexplained increase in hospitalizations associated with acute renal failure "might be attributed to actual increases in [acute renal failure] among hospitalized patients or to changes in the way it is diagnosed, defined, or reflected in hospital discharge codes." It might also be a function, in part, of the aging of the U.S. population, "with greater numbers of older adults having diabetes and hypertension, both of which are major factors and comorbidities for kidney disease."

The study findings are limited by their basis in medical records, which precludes the assessment of classification validity, particularly for the diagnosis of acute renal failure, because no standardized diagnostic criterion exists, the authors noted. Additionally, the study data are subject to sampling variability and do not allow for race- or ethnicity-based analyses, they said.

Limitations notwithstanding, the findings underscore the need for screening and early detection of kidney disease, as well as the need for standardized diagnostic criteria for acute renal failure, the authors wrote. ■