CMS Poised to Launch Pay-for-Reporting Program

The small bonus payment for physicians who report on selected quality measures goes into effect July 1.

BY MARY ELLEN SCHNEIDER
New York Bureau

Starting July 1, physicians who report on selected quality measures will have a chance to earn a small bonus payment from Medicare.

The program, called the Physician Quality Reporting Initiative, was mandated by Congress and offers incentive payments to physicians who report on one to three quality measures. By doing so, physicians can earn a bonus of up to 1.5% of their total allowed Medicare charges during the 6-month reporting period.

Although even the maximum compensation isn't enough to make anyone rich, some physician organizations are advising their members to take a good look at the program because it may be the first step toward a performance-based payment system. "By involving ourselves in the process we can have feedback," said Dr. James Stevens, a neurologist in Fort Wayne, Ind., and a member of the medical economics and management committee of the American Academy of Neurology.

Deciding whether participation makes sense is a calculation that has to be made by each practice, Dr. Stevens said. Those who give it a try will get a confidential report from the Centers for Medicare and Medicaid Services about how they are doing and have a chance to provide information on what works and what doesn't.

"This experience will likely be helpful in the future," said Brett Baker, director of regulatory affairs at the American College of Physicians, adding that although the bonus payment is not significant, having some type of financial incentive attached may be enough to get people's attention.

To get started, physicians must familiarize themselves with the program and the measures and figure out for how many patients they will be able to gather and report data, Mr. Baker said. They also should consider the technical issues involved in reporting and how feasible it will be to make those changes. "It's certainly a challenge for everyone to ramp up to do this in a short period of time," he said.

CMS officials have selected 74 quality measures that can be used by physicians across specialties. If four or more measures apply, physicians must report on at least three measures for at least 80% of cases in which the measure was reportable. If no more than three measures apply, each measure must be reported for at least 80% of the cases in which a measure was reportable.

Although payments will be provided to the holder of the tax identification number, the results will be analyzed at the physician level, the CMS said. As a result, Medicare officials are requiring that the National Provider Identifier number be used on all claims.

The reporting period will run from July 1 through Dec. 31, 2007, and all claims must reach the National Claims History File by Feb. 29, 2008.

Any Medicare-enrolled eligible professional can participate in the program, regardless of whether they have signed a participation agreement with Medicare to accept assignment on all claims. In addition, physicians are not required to register to participate in the Physician Quality Reporting Initiative. Medicare will use a claims-based reporting system for the program and will require practices to enter either CPT Category II codes or temporary G-codes where CPT-II codes are not available.

The codes can be reported on either paper-based CMS 1500 forms or electronic 837-P claims. The quality codes should be reported with a $0.00 charge.

The bonus payments will be made in a lump sum in mid-2008, CMS officials said. Physicians can earn up to a 1.5% bonus, subject to a cap. The cap is structured to ensure that physicians who do more reporting will receive higher payments.

Under the law that established the Physician Quality Reporting Initiative, the program is excluded from a formal appeals process. However, CMS officials said they plan to establish some type of informal inquiry process. In addition, they are currently developing a validation procedure for the reporting process that is likely to involve sampling.

In addition to the bonus payment, physicians who participate will receive a confidential feedback report from the CMS sometime in 2008. Those reports are expected to include reporting and performance rates. However, the quality data reported in 2007 will not be publicly released.

For 2008, the CMS is required under statute to propose the new measures in August 2007 and finalize them by Nov. 15, 2007. Next year's measures are likely to include structural measures, such as the use of electronic health records or electronic prescribing technology. CMS officials are also working on the possibility of allowing physicians to report using either registry-based systems or electronic records systems in 2008.

Of the 74 measures released by the CMS, 21 apply to family medicine, said Dr. Rick Kellerman, president of the American Academy of Family Physicians. In an effort to make the process more user friendly, AAFP officials are strongly urging family physicians to report on the three diabetes measures available. This will make it easier for physicians to report because they can concentrate on a single diagnosis, Dr. Kellerman said.

The AAFP is developing a data collection sheet for physicians and another for the back office staff, he said. The academy also is developing tools to help physicians calculate their potential bonus payment under the program.

Because the CMS has selected measures that have been vetted by physician organizations and reflect current medical practice, most physicians should not have a problem with that aspect of the program, said Dr. Janet Wright, a cardiologist in Chico, Calif., and chair of the performance assessment task force of the American College of Cardiology.

The hurdle will be in changing the workflow in the office, she said. For some, the bonus payment will not be enough to offset the cost of making these administrative changes. The ACC is developing a special coding form that can be attached to the visit encounter form in an effort to streamline the process. In addition, participation in the program will help provide the CMS with information on the real-life experiences of cardiologists, Dr. Wright said. ■

More information on the Physician Quality Reporting Initiative is available online at www.cms.hhs.gov/PQRI.

Regional Networks to Form the Basis of New Quality Push

BY DENISE NAPOLI
Assistant Editor

WASHINGTON — The Bush administration aims to move forward on its goal of health care price and quality transparency through its new Value-Driven Health Care Initiative.

The initiative, which will certify and support regional collaboratives of health care payers, providers, and purchasers, was announced by Health and Human Services Secretary Mike Leavitt at a press briefing sponsored by the journal Health Affairs.

Participants in the program's collaborative groups, called Value Exchanges, will be able to share practices for increasing quality with fellow members through a federally funded learning network, for which $4 million has been earmarked in the proposed 2008 federal budget. Providers who can demonstrate improved transparency and quality are also likely to reap rewards from payers.

Mr. Leavitt gave as an example one private insurer affiliated with a pilot Value Exchange in California that paid out as much as $50 million to physicians who had met certain standards of quality care. "[Insurers] rewarded the quality practice. But if you don't have a standard way of measuring [quality], then those [bonuses] are not able to be developed or executed," he said.

Dr. John Tooker, executive vice president and chief executive officer of the American College of Physicians (ACP), said that it is too soon to determine the success of the pilot programs.

"I think the [level of physician] engagement in the program will determine how much value is to be derived from the program," he said.

In 10 years a project to share practices that produce high quality health care will have matured into a national network using electronic medical records.

However, "You've got to start somewhere. The ACP and many other medical societies have been supportive of moving the evidence-based performance measures into meaningful field testing. … These Value Exchanges provide an opportunity to test these measures."

Quality standards by which care will be measured are being formulated by physician groups.

Leadership from groups such as the ACP, the Society for Thoracic Surgery, and the American Academy of Family Physicians, as well as the American Medical Association's Physician Consortium for Performance Improvement, will provide the basis, said Dr. Carolyn Clancy, director of the Agency for Healthcare Research and Quality. "This is what the profession believes is the best science," said Dr. Clancy at the meeting. Though the program will use national measures of quality, it will be governed locally.

Local control is important for two reasons, Mr. Leavitt said. The first deals with the initial collection of medical records with which the program would develop comparisons between providers. "Until we have a robust system of electronic health records, the [process of acquiring] this information is essentially going in and looking at medical records—most of the time, paper records—to determine what quality is and when it occurs. That, by its very nature, is local."

The second reason why local facilitation is important has to do with trust, he said. "This is a very significant change and it requires people to work together collaboratively in order to be comfortable. [Doctors] will be much less likely to work with Washington, where they can't affect the process, [rather than local networks]."

To become a Value Exchange, a collaborative group must submit an application to the Department of Health and Human Services detailing its adherence to four "cornerstones" of the program. In addition to the adoption of an electronic medical records system, these cornerstones include public reporting of performance; public reporting of price; and the support of incentives rewarding quality and value.

Mr. Leavitt sketched a rough timeline for widespread adoption of the program.

"Five years from now, the word 'value' will be a regular part of the medical lexicon," he said. "Ten years from now, this network will have matured into a national network."

Electronic medical records have to be the backbone of this system, he said. ■

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