

PQRI: should you take part?

Mary Kruczynski

Director of Policy Analysis, Community Oncology Alliance, Washington, DC

After the passage of the Tax Relief and Health Care Act of 2006, the Centers for Medicare & Medicaid Services implemented the Physician Voluntary Reporting Program in July 2007, an incentive program that allows practices to earn a bonus on Medicare billings. Now called the Physician Quality Reporting Initiative (PQRI), it includes 119 measures for which physicians collect and report their practice data. The program is largely considered a precursor to a mandatory pay-for-performance program Medicare will roll out, probably within the next two years. Although most people agree that efforts to improve quality and standardize physician quality measures are beneficial, many are skeptical that PQRI will achieve the desired outcome. But documenting quality is in everyone's future. In this article, the author takes a look down that path.

Guest Editor's Note: *The Physician Quality Reporting Initiative (PQRI) isn't going away. But it seems that practitioners are having a hard time facing up to that fact: only 16% of eligible physicians took part in the program in 2007. There are probably a number of reasons why many practices did not take part. But the demand for accountability and measurement continues to grow, so if a practice has specific concerns about the details of PQRI, it needs to raise its voice for correction and adjustment.*

When the Physician Quality Reporting Initiative (PQRI) was first launched last year, a number of people raised concerns, not only about the measures themselves, but about the administrative burden of taking part. Many found it necessary to create an appendix to their "Superbill" in order to effectively capture the data required to report quality codes. Many also had to make changes in their practice management software, and often additional support staff had to be hired. Some practices even increased salaries to those responsible for championing this program.

As we go forward, many anxiously await the results of their efforts, wondering not only how much they will be paid to for compliance with the Physician Voluntary Reporting Program, but if, in fact, they will even receive a check. Unfortunately, the Centers for Medicare & Medicaid Services (CMS) was unable to tell providers whether or not they successfully reported quality measures in 2007. And providers won't know whether they were successful until after the February 29, 2008, deadline for reporting last year's claims, when an analysis will be made. Successful reporting translates into a possi-

ble 1.5% bonus based on total allowed charges, subject to a cap. Various parties have speculated as to what that dollar figure might be; the number ranges from \$600 to \$1,600. Bonus payments will be made to the holder of record of the taxpayer identification number.

This year, participants won't have to wonder whether they are reporting quality measures appropriately. CMS plans to provide interim feedback reports, beginning in the second quarter. Such feedback may include participation comparison by specialty, clinical performance trends, and even beneficiary outcomes.

Going digital

The Physician Assistance and Quality Initiative Fund will provide \$1.35 billion in additional physician payments payable upon successful completion of the 2008 PQRI program. This is a staggering number; is the program worth such an expenditure? Another option would have been supplemental payments to practices implementing electronic health records (EHR), which, theoretically, would enhance quality and performance within their own clinics by allowing transparency, accountability, and centralized clinical data. As it turns out, this year CMS will partner with several self-nominated EHR vendors to explore the feasibility of reporting to the agency electronically.

CMS very much wants to promote EHRs and

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Correspondence to: Mary Kruczynski, 749 Bridge View Road, Langhorne, PA 19053; telephone: 860-305-4510; fax: 860-644-9119; e-mail: marykay4cancer@yahoo.com.

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How CMS arrived at its quality measures

Where did the 119 quality measures within the 7 categories for 2008 originate? There are a variety of sources. Some of the measures were carried over from 2007. Others were developed by the:

- American Medical Association Physician Consortium for Performance Improvement;
- AQA Alliance (formerly the Ambulatory Care Quality Alliance);
- National Quality Forum (which endorsed 59 of the measures);
- Pennsylvania Medicare Quality Improvement Organization (non-physician and structural measures).

e-prescribing. In 2008, physicians and non-physician healthcare professionals who cannot meet PQRI measures will still be allowed to take part in the initiative by reporting on their use of health information technology. Hopefully, this will encourage more widespread use of these technologies.

Recognizing that healthcare professionals would not want to add to their already burdensome workload, various vendors have introduced products that help providers achieve the 80% compliance benchmark. Interwoven into many of these software packages are additional measures that actually encourage providers to adhere to an even greater level of quality than that required by the PQRI program.

Physician awareness of and engagement in documenting quality are crucial to success or failure. In the

not-too-distant future, the ability to view, in aggregate, your own clinical data may be the negotiating point among providers, payers, and—eventually—patients. Going forward, data will be used as the spectrum of analysis that defines quality and in turn, reimbursement.

Care disparities

Healthcare in the United States may be the most technologically advanced and resource-intensive in the world, but the variability of treatment options, even within the walls of a single clinic, is wide-ranging for a single diagnosis. Evidence-based therapies that are also economically prudent need to become the treatment options of choice.

In June 2007, Congressman Pete Stark, Chairman of the Ways and Means Subcommittee on Health, defined comparative clinical effectiveness “as a means comparing the relative value of different clinical treatments, including drugs, devices, tests, procedures bandages, pills, and anything else you want to take and try to get a comparative ranking. All too often physicians and patients struggle to understand when a new product, diagnostic test, or surgical procedure will be most helpful, or how to choose among existing courses of treatment.”

On the topic of pay for performance, Mr. Stark said: “We already do that: providers perform, and we pay. It’s just that we pay the same whether the service is done on the right people at the right time, or the wrong people at the wrong time! We really have to know what the effective and appropriate services are, before we can know how to reward the care that achieves the best outcomes.”

Registry-based reporting

CMS recognizes the potential value of providing data on quality measures through an appropriate medical registry (registry-based reporting). But the agency did not find it feasible to implement this type of reporting just yet. However, CMS will select registries from self-nomination letters that were received by January 4, 2008. The registries would need to undergo feasibility testing to prove their technical capability, inclusion of key data elements, and the level of complexity and effort required for testing. Information on the results of feasibility testing will eventually be published on the PQRI Web site (www.cms.hhs.gov/PQRI/).

In essence, it would seem that Congress is creating a provider path toward quality performance in which practitioners adhere to nationally recognized standards of care.

The jury is still out on the success or failure of PQRI and its ability to demonstrate quality. However, one can be certain that healthcare professionals will eventually have to account for quality outcomes within their practices. If the quality program instituted by CMS does nothing more than encourage you to think about the future of your practice and how best to invest in that future, then it will have achieved its goal.

ABOUT THE AUTHOR

Affiliation: Ms. Kruczynski is Director of Policy Analysis, Community Oncology Alliance, Washington, DC.

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