Physicians now have nine 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 in April.

Under the Physician Quality Reporting Initiative (PQRI), launched last July, physicians can earn up to a 1.5% bonus on 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,” the acting administrator of the CMS, 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 data reporting, more health professionals will submit quality data to CMS.

PQRI in 2008 allow claims-based reporting. Here are details on the claims-based option:

- Physicians can choose to report on individual measures for a full year from Jan. 1 to Dec. 31, 2008. Under this option, physicians must meet the 80% threshold that they started in May or June, he said.

- 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 didn’t have the second report yet should still consider the full option year, Dr. Michael T. Rapp, director of the quality measures group at CMS, said during a CMS-sponsored provider call on PQRI. Because 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 for inadequate hemodialysis. In order to qualify for payment using measures groups, physicians must 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 will release the list of participating registries in late August. Despite the late announcement of qualified registries, physicians can still sign up for 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 insurers will be able to use registry-based reporting will be unclear until CMS releases the list of participating registries in late August, he said. While subspecialties such as thoracic surgery do have well-established registries, there is not a registry commonly used by all internists at this point, he said.

- Another unanswered question is how CMS will ensure that the data being submitted by registries are accurate, Mr. Whitman said.

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

Options Involve Claims-Based and Registry-Based Reporting

Three of the nine options outlined by the Centers for Medicare and Medicaid Services for reporting data to PQRI in 2008 allow claims-based reporting. Here are details on the claims-based option:

- Physicians can choose to report on individual measures for a full year from Jan. 1 to Dec. 31, 2008. Under this option, physicians have three or more applicable measures to report on all three measures for at least 80% of their patients. 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 also has established three reporting options for reporting to a registry for a half-year 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.

Medicare Advisers Protest Agency’s Plan to Publish PQRI Data

BY J OEL B. F INKELSTEIN Contributing Writer

WASHINGTON — A panel of Medicare advisers warned agency officials against moving forward with a proposal to make public list of doctors participating in a voluntary federal quality reporting effort.

The Physician Quality Reporting Initiative was created under a provision of 2006 tax relief and offers physicians a 1.5% Medicare bonus for sending data on several clinical measures to the Centers for Medicare and Medicaid Services.

So far, about 16% of Medicare participating physicians have elected to participate in PQRI, although about half of those who are not participating see fewer than 50 Medicare patients a year, according to agency officials.

“We have had in place for a number of years public reporting of quality information and now cost information for a number of settings, hospitals most prominently, dialysis facilities, nursing homes, and home health agencies,” Dr. Barry Straube, CMS chief medical officer, said at a meeting of the Practicing Physicians Advisory Council.

“The agency, the [Health and Human Services] department, the White House, [lawmakers], and many consumer advocates and employers would like for us and everyone to start focusing more on physician office public reporting,” he said.

Dr. Straube announced at the meeting that the CMS was considering whether to publish the names of physicians who have agreed to participate in the PQRI as well as to indicate whether those physicians were paid the incentive, a proxy for whether they met or exceeded the agency’s reporting requirements.

That proposal didn’t sit well with several PPAC members.

“I am concerned that you are taking these PQRI data that were presented to the physician community for one reason and now you’re taking that information garnered out of that and you’re going to put it on a Web site,” said Dr. Tye Ouzouinan, an orthopedic surgeon in Tarzana, Calif.

Publishing the names of PQRI participants could create a public perception that physicians who are not on the list are not quality providers, he told Dr. Straube.

The perception might be even worse for those physicians who chose to participate, but were not able to fully comply, said Dr. Fredrica Smith, an internist in Los Alamitos, N.M.

“It’s not that they are not listed as having participated and failing, which has horrible implications, said Dr. Smith. A solo practitioner, Dr. Smith said that she spent 1-2 hours a week trying to comply with the reporting requirement only to be left confused by the data.

CMS officials told the council that they were applying the reporting requirements flexibly and that they expected most physicians who chose to participate to receive the incentive payment.

Despite such assurances, PPAC recommended that the CMS give physicians and their colleagues enough lead time to determine whether they want to participate in the initiative, knowing their participation will be published, before that information is made available to the public.

“If you are going to put [those] data up there, you need to advise the physician community, with ample notice,” Dr. Ouzouinan said.

Dr. Straube said he understood council members’ concerns, but that it was inevitable, given the push for transparency, that such information will some day be made public.

“I suspect that this is going to happen sometime in the future. I don’t think that the physician office setting will not have some need to be publicly accountable,” he said.