

**Department of Health and Human Services
Centers for Medicare & Medicaid Services**

2008 Physician Quality Reporting Initiative: Establishment of Alternative Reporting Periods and Reporting Criteria

Action: Establishment of alternative reporting periods and alternative criteria for satisfactorily reporting quality measures for the 2008 Physician Quality Reporting Initiative (PQRI) as authorized by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173) which was enacted on December 29, 2007.

Summary:

This document establishes the MMSEA 2008 PQRI provisions for:

- (1) alternative reporting periods and alternative criteria for satisfactorily reporting measures groups; and,
- (2) alternative reporting periods and alternative criteria for satisfactorily reporting through registry-based reporting.

These provisions provide increased opportunities for eligible professionals to report PQRI quality measures and the possibility to earn incentive payments for satisfactory reporting.

Effective date: April 15, 2008

Background:

The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS named this program the Physician Quality Reporting Initiative (PQRI). TRHCA requires CMS to pay eligible professionals who satisfactorily report data on quality measures an incentive payment equivalent to 1.5 percent of their total allowed charges for Medicare Physician Fee Schedule (PFS) covered professional services (referred to as total allowed charges) furnished during the 2007 reporting period (July 1, 2007 – December 31, 2007). The statute defines satisfactory reporting to be reporting of up to 3 applicable measures in at least 80 percent of the cases in which such measure is reportable. A total of 74 clinical quality measures were available for reporting for 2007. Reporting for 2007 occurred only via claims.

TRHCA also required that CMS establish a PQRI measure set for 2008, including structural measures. In the 2008 PQRI, there are a total of 119 measures that eligible professional can select from: 117 clinical quality measures, and 2 structural measures (use of electronic health records and electronic prescribing). (See 2008 PFS Final Rule published November 27, 2007, 72 Fed. Reg. 66222, at 66336-66359, available on the CMS web site at: <http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1385fc.pdf>) The complete specifications for the 119 measures that make up the 2008 PQRI are available at: <http://www.cms.hhs.gov/PQRI/downloads/2008PQRIMeasureSpecifications123107.pdf>.

TRHCA also required CMS to address the submission of PQRI measures data through registries. In the 2008 PFS Final Rule, CMS described plans to test two methods for submission of quality measures data through registries during 2008. The 2008 PFS Final Rule did not provide for any incentive payment for eligible professionals who only submitted their quality measures data through registries under the testing process. The testing process is currently underway, with test data submission slated to begin in July, 2008. Data submission for the testing process will conclude by September 1, 2008.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) was enacted on December 29, 2007 (Pub. Law 110-173). MMSEA authorizes CMS to make PQRI incentive payments for satisfactory reporting quality measures data with respect to services furnished in 2008. For 2008, eligible professionals who meet the criteria for satisfactory submission of quality measures data on services furnished during the reporting period, January 1, 2008 – December 31, 2008, will earn an incentive payment of 1.5 percent of their total allowed charges for PFS covered professional services furnished during that same period (the 2008 calendar year).

MMSEA requires that for 2008 and 2009 the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting groups of measures. It also requires that for 2008 and 2009 the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting quality measures data through registries. In 2008, eligible professionals may earn an incentive payment of 1.5 percent of their total allowed charges for PFS covered professional services furnished during the respective alternative reporting periods based on data submitted via these mechanisms. While TRHCA established a cap on incentive payments for 2007, based on an average per measure payment amount, there is no cap on incentive payments under MMSEA for 2008 and 2009.

Alternative Reporting Periods and Alternative Criteria for Satisfactorily Reporting for 2008: Measures Groups and Registry-Based Reporting

(a) General

This document establishes for 2008:

- (1) the alternative reporting periods and alternative criteria for satisfactorily reporting measures groups; and,
- (2) the alternative reporting periods and alternative criteria for satisfactorily reporting through registry-based reporting.

The provisions of this document do not apply for the PQRI in 2009. Requirements for 2009 PQRI will be established at a later time.

These alternatives supplement the reporting period and the reporting criteria previously set forth in the 2008 PFS Final Rule. Eligible professionals who satisfactorily report under any of the alternatives set forth in this document, or for the reporting period and under the reporting criteria set forth in the 2008 PFS Final Rule will be eligible for a 1.5 percent incentive payment with respect to services furnished during the applicable reporting period. For example, satisfactory reporting for only the July 1, 2008 – December 31, 2008, reporting period will qualify for a 1.5 percent incentive payment but only for services furnished during that reporting period.

Eligible professionals may potentially qualify as satisfactorily reporting under more than one of the alternative reporting criteria and for more than one reporting period. However, this will result in only one incentive payment based on the longest reporting period for which the eligible professional satisfactorily reports.

(b) Measures Groups

For 2008, there are four measures groups: Diabetes Mellitus, End Stage Renal Disease, Chronic Kidney Disease (CKD), and Preventive Care. Each of the measures groups contains at least four PQRI measures. Eligible professionals electing to report a group of measures must report all measures in the group that are applicable to the patient.

The measure groups are composed of the following PQRI measures:

Diabetes Mellitus:

- Measure Number 1 – Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus
- Measure Number 2 – Low Density Lipoprotein Control in type 1 or 2 Diabetes Mellitus
- Measure Number 3 – High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus
- Measure Number 117 – Dilated Eye Exam in Diabetic Patient
- Measure Number 119 – Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

End Stage Renal Disease (ESRD):

- Measure Number 78 – Vascular Access for Patients Undergoing Hemodialysis
- Measure Number 79 – Influenza Vaccination in Patients with ESRD
- Measure Number 80 – Plan of Care for ESRD Patients with Anemia
- Measure Number 81 – Plan of Care for Inadequate Hemodialysis in ESRD Patients

Chronic Kidney Disease (CKD):

- Measure Number 120 – ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD
- Measure Number 121 – CKD: Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)
- Measure Number 122 – CKD: Blood Pressure Management
- Measure Number 123 – CKD: Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)

Preventive Care:

- Measure Number 39 – Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
- Measure Number 48 – Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- Measure Number 110 – Influenza Vaccination for Patients > 50 Years Old
- Measure Number 111 – Pneumonia Vaccination for Patients 65 Years and Older
- Measure Number 112 – Screening Mammography
- Measure Number 113 – Colorectal Cancer Screening
- Measure Number 114 – Inquiry Regarding Tobacco Use

Measure Number 115 – Advising Smokers to Quit
Measure Number 128 – Universal Weight Screening and Follow-Up

(c) Alternative Reporting Periods for Measures Groups

- (1) Measures Groups using Claims-based data submission: The alternative reporting period for quality measures data for measures groups submitted through claims-based reporting is July 1, 2008 – December 31, 2008. The claims-based reporting mechanism for measures groups will be first available July 1, 2008.
- (2) Measures Groups using Registry-based data submission: The alternative reporting periods for quality measures data for measures groups submitted through registry-based data submission are January 1, 2008 – December 31, 2008, or July 1, 2008 – December 31, 2008.

(d) Alternative Criteria for Satisfactorily Reporting Measures Groups

- (1) These alternative reporting criteria for quality measures data for measures groups apply regardless of whether the measures are reported through claims-based submission or through registry-based reporting. However, the “G-code” described in subsection (d)(8) required for claims-submission of measures groups will not be implemented until July 1, 2008. Therefore, the July 1, 2008 – December 31, 2008, reporting period is the only available reporting period for measures groups data submitted on claims.
- (2) The alternative reporting criteria for quality measures data for measures groups reported for the January 1, 2008 – December 31, 2008, reporting period are 30 consecutive patients for whom the measures of one measures group apply; or 80 percent of Medicare patients for whom the measures of the measures group apply, without regard to whether the patients are consecutive. The January 1, 2008 – December 31, 2008, reporting period for measures groups applies only to registry-based reporting, not claims submission. See section (d)(1).
- (3) The alternative reporting criteria for quality measures data for measures groups reported for the July 1, 2008 – December 31, 2008, reporting period are: 15 consecutive patients for whom the measures of one measure group apply for measures groups reported through registry-based reporting; 15 consecutive Medicare patients for whom the measures of one measures group apply for measures groups reported through the claims mechanism; or 80 percent of Medicare patients for whom the measures of the measures group apply, without regard to the submission mechanism used or whether the patients are consecutive.
- (4) “Patients” or “Medicare patients” under these reporting criteria means Part B Medicare Fee-For-Service (FFS) patients. Non-FFS Medicare (*e.g.* Medicare Part C patients including those enrolled in Private FFS plans) and/or Non-Medicare patients may only be included in registry based reporting under the consecutive patient criteria. See sections (f)(2) and (f)(3). “Non-Medicare patients” under these reporting criteria means persons not enrolled in Part B or Part C of Medicare.

- (5) “Consecutive” means next in order by date of service. Patients are considered consecutive without regard to gender even though some measures in a group (e.g., preventive care measures) may apply only to males or only to females.
- (6) “Patients for whom the measures of one measures group apply” means patients to whom services are furnished during the reporting period and for whom the measures of a particular group apply as defined by the denominator of the measures.
- (7) Measures groups reporting requires that eligible professionals must report on each of the measures in the measures group that is applicable to the patient.
- (8) “G-Code” for Claims-based submission of measures groups. Eligible professionals must initiate the 15 consecutive Medicare patients beginning on or after July 1, 2008, for measures groups submitted by the claims mechanism, by reporting a group-specific “G-Code.” This indicates the eligible professional’s intent to report a specific measures group starting with the patient for whom the “G-Code” is submitted. The use of a “G-Code” is not required for registry-based submission with respect to measures groups.

(e) Alternative Reporting Periods for Registry-Based Data Submission

- (1) The alternative reporting periods applicable to the Alternative Criteria for Satisfactorily Reporting Through Registry-Based Data Submission under section (f) are January 1, 2008 – December 31, 2008, or July 1, 2008 – December 31, 2008.

(f) Alternative Criteria for Satisfactorily Reporting Through Registry-Based Data Submission

- (1) The alternative reporting criteria for registry-based reporting of measures groups are the same as stated in subsection (d)(1-6) for measures groups.
- (2) The alternative reporting criteria for registry-based reporting of individual measures are a minimum of 3 PQRI measures applicable to the services furnished by the eligible professional during the reporting period for at least 80 percent of the cases in which each such measure is reportable.
- (3) Although quality measures data on consecutive patients reported through registry-based reporting for measures groups may include some non-Medicare patients, the string of consecutive patients must be established in such a way as to include some Medicare patients. Quality measures data that is reported through the claims mechanism or under other registry-based reporting criteria can only include Medicare patients.

(g) Additional Requirements for Registry-Based Data Reporting

- (1) To qualify to submit data under the registry-based reporting alternatives for 2008, a registry must have been in existence on January 1, 2008, and the registry also must meet certain technical and other requirements that CMS specifies. CMS will post those registry requirements by April 30, 2008 on the CMS website.
 - (A) The requirements will include, but not be limited to, submission of a self-nomination by a certain date. Registries that participated and/or self-nominated for the 2008 registry testing process will need to submit a new self-nomination specific to this new process in order to be considered for potential qualification.
 - (B) The requirements will include, but not be limited to, the registry having entered (or entering) into appropriate legal arrangements that provide for the registry's receipt of patient-specific data from eligible professionals, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in the PQRI program.
 - (C) Each registry seeking to submit data described in (g)(1)(B) will be required to meet all technical and other requirements CMS identifies for registries to submit such information.
 - (D) CMS will post on the CMS website by August 31, 2008, the names of those registries that qualify. This publication will be accomplished through familiar CMS communications channels, including a posting to the CMS PQRI website (at: <http://www.cms.hhs.gov/pqri>).
 - (E) Registry-based submissions under the 2008 registry-based reporting alternatives will begin after the completion of the 2008 registry testing process.
- (2) Eligible professionals must comply with all applicable laws in establishing a relationship with a registry whereby the registry will report quality measures data to CMS on their behalf based on the data the eligible professional submits to the registry. The eligible professional will need to document and be able to demonstrate that this relationship has been established, and must attest to the validity of the data submitted by the eligible professional to the registry. The registry-based submission must meet the criteria for satisfactory reporting for PQRI measure results and/or measures group results.
- (3) Registries must submit to CMS all required data that will include reporting and performance rates on PQRI measures or PQRI measures groups and numerator and denominators for the performance rates. Registries must attest that the eligible professional has satisfactorily reported data for clinical quality measures or measures groups under the PQRI program. Registries must specify the reporting criteria and reporting periods for which the eligible professional satisfactorily reported. Registries must also attest that all applicable statutory, regulatory, and contractual requirements for reporting of information to CMS have been met.
- (4) Eligible professionals who submit measures both through registries and through claims-based submission will be eligible to receive an incentive payment provided they meet the requirements for satisfactory reporting under either reporting mechanism. Qualification under both submission mechanisms will result in only one incentive bonus payment based on the longest reporting period for which the eligible professional satisfactorily reports.

- (5) Registry reporting for each eligible professional must be on 2008 PQRI measures for patient services furnished during the applicable reporting period.