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Physician Quality Performance Initiative (PQRI): Theory and Practice

By Bettina Berman, RN

Background: Medicare, the nation's single largest health care purchaser, pays for health care services for almost 45 million beneficiaries[1] – a number that is expected to swell in the coming decade. Current Medicare expenditures represent 14% of federal spending, and the projected annual growth rate is 7.5% between 2008 and 2017.[1] In light of this, the financial viability of Medicare and payment reform will likely continue to dominate future health policy discussions in the United States.

For several years, research has demonstrated that more, and more expensive, health care is not necessarily better health care. A recent policy brief issued by the Dartmouth Institute for Health Policy and Clinical Practice reported that the geographical variations in Medicare spending are almost entirely explained by differences in the volume of Medicare services rendered to beneficiaries. Perhaps more compelling are findings that a higher volume of services and higher spending do not produce better outcomes of care.[2]

In 2005, the Centers for Medicare and Medicaid Services (CMS) issued its Quality Roadmap with strategies for achieving higher health care quality for Medicare beneficiaries while curtailing skyrocketing health care costs. One of these strategies – Value-Based Purchasing (VBP) – sought to transform Medicare from a passive payer to an active purchaser of high-quality efficient care. CMS considers VBP to be the basis for all future Medicare reimbursement and payment systems.

The cornerstones of VBP are: development of clinical, evidence-based measures; resource utilization measurement; and payment system redesign.[3]

Physician Quality Reporting Initiative (PQRI): The Tax Relief and Health Care Act of 2006 formed the legislative background for the PQRI program, one of several VBP initiatives implemented by CMS. Officially launched on July 1, 2007, PQRI consists of processes, outcomes, and structural measures used to assess evidence-based standards of clinical care. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made the PQRI program permanent and required that, by 2010, CMS develop a more comprehensive plan for VBP that includes measures, incentive methodology, data strategy and infrastructure, and public reporting. Currently a voluntary pay-for-reporting quality initiative, PQRI is widely regarded as a precursor to a federal pay-for-performance (P4P) program for individual Medicare providers. Now in its third year, the program offers physician and nonphysician providers a financial incentive in return for submitting quality-based G-codes (ie, Medicare-specific codes) or Current Procedural Technology-II claims codes.

The 2009 PQRI consists of 153 unique quality measures and 7 quality measures groups related to patient care provided in both the inpatient and outpatient settings. In 2009, new individual measures were introduced in the areas of HIV, back pain, and preventive care, and options for reporting on measures groups were expanded to include preventive care, coronary artery bypass graft, rheumatoid arthritis, perioperative care, and back pain.

Eligible professionals include physician and nonphysician providers who accept Medicare Part B payment and hold an active National Provider Identifier. The payment incentive for 2009 is 2% of total allowed charges for covered services furnished during a reporting period (ie, January 1-December 31, 2009 for all measures, and a July 1-December 31, 2009 option for registry and measures group-based reporting).[4] In 2009, the measure for electronic prescribing (e-Rx) became a separate VBP-P4P

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initiative under CMS, offering an additional 2% financial incentive to physicians who utilize e-Rx in the outpatient setting. Providers who fail to meet e-Rx requirements will be faced with a reduction in payment starting in 2012.[5]

In addition to the small financial incentive, early adopters of PQRI have benefited from their experience with the program's structure and have provided CMS and the measure developers with feedback on the quality measures and the program methodology. Such an understanding of the framework for a national quality-reporting program prepares providers for future programs.[6] Although the release of the initial provider report from CMS revealed some systemic and methodologic issues, providers are likely to gain useful benchmarking data from future reports.

Experience with the PQRI Program at Jefferson University Physicians Faculty Practice Plan (JUP): JUP is a faculty practice plan of 450 primary care and specialty physicians in 19 practices. Recognizing the need to measure and improve quality of outpatient care, the JUP Clinical Care Subcommittee (CCS) focuses on creating a JUP-wide quality and safety culture, monitoring national and local trends in quality management and P4P, selecting and developing quality measures and initiatives in alignment with nationally endorsed measures, and stimulating performance improvement.

The CMS PQRI program was implemented as a JUP-wide performance project in 2006. Primary care practices were the first to identify measures for reporting, and practice participation grew as additional subspecialty measures became available. Of 200 physicians (15 practices) who participated in the 2007 program, approximately 50% qualified for a bonus payment. The CCS expects that all 19 practices will have submitted PQRI measures to CMS by late spring of 2009.

Implementing the PQRI program across 19 faculty practices was a complex undertaking that required strong efforts from interdisciplinary teams. Barriers were abundant; for example:

- Professional and nonprofessional education was needed regarding the program concept and the new lexicon of quality codes.
- Complex measure specifications presented difficulties.
- The existing infrastructure was insufficient to support reporting requirements and changes to current workflow processes.
- Physician buy-in issues were related to the size of the financial incentive, the increase in workload, and acceptance of quality measures as accurate indicators of quality patient care.
- Lack of transparency of the algorithm used for reporting compliance and lack of timely feedback reports from CMS created delays in providing meaningful feedback to practices.

While many of the barriers encountered by the JUP practices were similar to the nationwide findings by CMS, a key factor to successful PQRI implementation across JUP has been the collaboration between representatives from the practices, JUP administration, and the JUP performance improvement team. Continued support from CMS in terms of national provider calls, information posted on the CMS Web site, and clarification of questions via email has been invaluable to the success and the expansion of the program across the faculty practices.

It will be interesting to see where the CMS Quality Roadmap will lead us in the future. The CMS plan for a VBP program for Medicare payment for professional services, required by MIPPA legislation, is due in less than a year (May 2010).

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