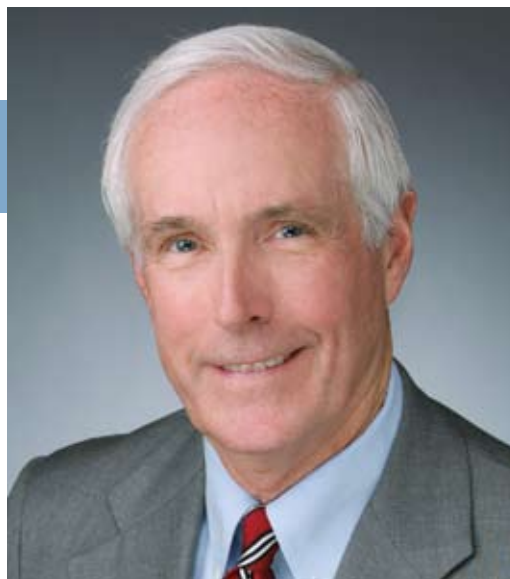


From my perspective



At this point, many surgeons seem disinterested in participating in the Physician Quality Reporting Initiative (PQRI) and other performance measurement programs. They say that the reporting process is too time-consuming and that the existing measures examine the most rudimentary aspects of patient care. These concerns are certainly valid. However, it is important for surgeons to look at the bigger picture when deciding whether to take part in these efforts because they are likely to play a key role in creating the road map the federal government is crafting for the future of health care delivery.

PQRI's origins

The PQRI was established in the 2006 Tax Relief and Health Care Act (TRHCA), which provided a 1.5 percent incentive payment for physicians who satisfactorily provided reports on up to three measures for at least 80 percent of their Medicare patients between July 1 and December 31, 2007. A total of 74 performance measures were available in 2007 for use by physicians and other health care professionals. The American College of Surgeons developed six measures that are applicable to many surgical specialties, whereas the American Academy of Ophthalmology produced three and the Society of Thoracic Surgeons generated four that are specific to their respective specialties. According to a report that the Centers for Medicare & Medicaid Services (CMS) released in February, 99,319 (15.74%) of Medicare participating physicians, practitioners, and therapists enrolled in the 2007 project. Slightly more than half of those participants qualify for the 1.5 percent bonus.

Unquestionably, most of the quality measures in the 2007 PQRI pilot project rewarded participating surgeons for adhering to very fundamental standards of care, such as the use and discontinuation of perioperative prophylactic antibiotics. However, these metrics were just a starting point for what is likely to evolve into a far more sophisticated set of standards of care and for deciding whether a physician provides high-quality services that merit payment.

“None of the existing evidence suggests that the momentum for linking payment to performance is slowing.”

Where it's going

Legislators and regulators are continually strengthening and broadening the PQRI. As Sens. Max Baucus (D-MT), and Charles E. Grassley (R-IA)—Chairman and Ranking Member, respectively, of the Senate Finance Committee—said in a January 23 letter to CMS, PQRI-related activities are intended to move the federal government “toward our long-term vision for a valid, consumer-friendly mechanism for measuring and rewarding the quality of care that clinicians provide.”

Congress passed legislation late last year—the Medicare, Medicaid, and SCHIP Extension Act (MMSEA)—which extended the PQRI through December 31, 2008. To increase consistency among the performance measures, TRHCA mandated that all measures in the 2008 program be endorsed by the National Quality Forum (NQF) or approved by the AQA (formerly the Ambulatory Care Quality Alliance). The 2008 PQRI comprises 119 measures, including the following:

- 59 measures from the 2007 PQRI metric set
- 38 measures from the American Medical Association Physician Consortium for Performance Improvement (AMA PCPI)

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- Seven nonphysician measures developed by a CMS Quality Improvement Organization
 - Two structural measures for practices that adopt e-prescriptions and electronic medical records
 - Five additional measures from the AQA for primary care physicians
 - Six measures from the American Podiatric Medical Association

Senators Baucus and Grassley say they intend to push for passage of legislation that would extend the bonuses throughout 2009 and beyond in order to “continue progress toward aligning Medicare payments more closely with the quality of care provided.” To that end, Congress has called upon CMS to specify an expanded and refined set of measures for use in 2009. To generate the new measures, Congress has directed CMS to continue adopting NQF-endorsed measures. For conditions that do not have available NQF-approved metrics, Congress has indicated that CMS may use other consensus-based measures from the AMA PCPI, AQA, specialty societies, and other stakeholders.

Congress also is asking that CMS explore alternative approaches for reporting quality measures. One option would be to develop composite measures for the treatment of chronic conditions or preventive care. It is anticipated that such measure sets would provide a more comprehensive view of patient care while targeting the aspects of the health care system in most need of reform. CMS is in the process of considering clinically related measure groups for diabetes, preventive care, chronic kidney disease, and end-stage renal disease.

Furthermore, CMS has started to address the use of clinical data registries to report on quality measures. As required under the MMSEA, CMS is attempting to establish alternative criteria and reporting periods for satisfactorily reporting measures under PQRI through registries.

Congress is also recommending that CMS take steps to allow physician group practices to employ a valid statistical sampling model to report performance information on an aggregate basis. Congress suggests that participating physician groups could report on specified measure sets that target costly chronic conditions using the model CMS has applied in Physician Group

Practice demonstration. This project launched in 2005 and provides incentives to large group practices that coordinate care to improve quality and lower spending. The government maintains that group practices, especially multidisciplinary group practices similar to those found within the Kaiser-Permanente network and the Mayo Clinic, promote enhanced care coordination and often deliver better patient outcomes. Therefore, Congress is suggesting that CMS develop means of recognizing multiple physician network structures.

Finally, Congress is requesting that CMS post on its Web site the names of clinicians and group practices that satisfactorily participate in PQRI. Indeed, Senators Baucus and Grassley have indicated that they intend to “pursue additional statutory authority for this important step in upcoming legislation.” This activity obviously is aimed at stimulating transparency among physicians and other providers.

What’s the College doing?

Clearly, the PQRI and its related programs are here to stay. As a result, transparency, outcomes data analysis, coordinated care, and, ultimately, compliance with evidence-based standards of care will be the touchstones of our evolving health care system. So, what do these changing expectations mean for surgeons, and what is the American College of Surgeons doing to help surgical practices during this transformative period in health care?

Essentially, surgeons can anticipate that the nation will steadily move in a direction where failure to report outcomes or to comply with evidence-based clinical guidelines will result in low or no payment for services from Medicare and Medicaid as well as other health plans. Right now these payors may be checking to ensure that surgeons and other clinicians are performing simple tasks that anyone worthy of a medical degree should know must be done, but soon the standards and requirements are likely to become much more specific and stringent. For example, a surgeon who operates on a patient with colon cancer may be required to remove a certain number of lymph nodes in order to appropriately stage the patient. These are the types of standards surgeons will need to set using information from

the College's data banks and other sources so they can help drive these kinds of performance measures.

The College has been directing many of its efforts toward ensuring that surgeons understand the import of outcomes reporting and of staying abreast of new standards of care. First of all, the ACS has been working with and educating surgeons who participate in the PQRI. We have presented teleconferences and webinars on the program, and individuals in the Division of Advocacy and Health Policy have authored *Bulletin* articles on the subject (for example, see page 48 of the January 2008 issue for an overview of this year's efforts). We also have created a Web page devoted entirely to the pay-for-reporting initiative at <http://www.facs.org/ahp/pqri/index.html>. Here surgeons can find up-to-date resources, including background materials, workflow sheets to assist in the measure collection process, a sample claim form, measure specifications, and answers to frequently asked questions.

Moreover, the College has developed a program to examine the implementation and burden of reporting to the PQRI. A total of 20 PQRI-participating surgical practices have volunteered for this tracking program. Using information from these practices, the ACS has identified implementation challenges in the PQRI and communicated them to CMS.

In addition, the College actively participates in the organizations that are vetting the PQRI measures. We have a seat on the AMA PCPI and on the NQF and have established the Surgical Quality Alliance to develop evidence-based performance measures that account for the unique nature of surgical care.

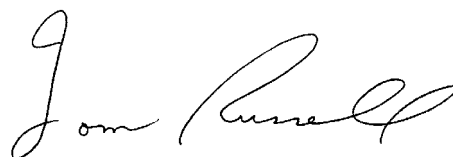
The College also continues to make progress in bringing the ACS National Surgical Quality Improvement Program into the private sector for outcomes evaluation and is working with other surgical specialty societies to generate performance measures that are common to all surgical specialties. Furthermore, the College has been enhancing its National Cancer Data Base (NCDB) and National Trauma Data Bank® to make these registries more useful in quality improvement efforts. In fact, the Commission on Cancer used some of the NCDB data to develop measures for cancer care, which NQF has endorsed.

To many surgeons, programs like the PQRI may seem to be annoying complications that currently will result in few positive tradeoffs for busy surgical practices. In fact, many of us would like to see these kinds of initiatives disappear so we can go back to the ways of the past. As is true with many things in life, however, there is no going back, so we have no choice but to move forward.

The bottom line is that surgeons need to be engaged in the PQRI and other programs aimed at developing a patient-based, high-quality health care system. None of the existing evidence suggests that the momentum for linking payment to performance is slowing. Rather, all indicators point toward these initiatives becoming increasingly relevant and prevalent.

At press time, we had just received word that CMS is changing the rules for PQRI participation in 2008 to encourage more physicians to report, so the College encourages you to get involved now when the process is easier. It will become more complex later on, but if your practice is already participating, accommodating changes in the future will be much easier for you and your staff.

An article about the new requirements and other updates on the PQRI will be published in the July issue of the *Bulletin*.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.