CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 265	**Date: MARCH 9, 2007**
	Change Request 5558

SUBJECT: Program Overview: 2007 Physician Quality Reporting Initiative

I. SUMMARY OF CHANGES: This Change Request transmits overview-level information on the Physician Quality Reporting Initiative (PQRI).

New / Revised Material
Effective Date: March 2, 2007
Implementation Date: April 9, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:
Funding for implementation activities will be provided to contractors through the regular budget process.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 265	Date: March 9, 2007	Change Request: 5558

SUBJECT: Program Overview: 2007 Physician Quality Reporting Initiative (PQRI)

Effective Date: March 2, 2007

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I. GENERAL INFORMATION

A. Background: CMS is developing and implementing pay for performance to encourage quality improvement and avoidance of unnecessary costs in the care of Medicare beneficiaries. Physician services comprise a significant component of the larger CMS value-based purchasing enterprise initiative that also includes hospitals, nursing homes, home health agencies, and dialysis facilities.

Introduction to the 2007 Physician Quality Reporting Initiative (PQRI)
On December 20, 2006, President Bush signed the Tax Relief and Health Care Act of 2006 (TRHCA). Division B, Title I, Section 101 of the TRHCA authorizes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. Eligible professionals, who chose to participate and successfully report on a designated set of quality measures for services paid under the Medicare Physician Fee Schedule and provided between July 1 and December 31, 2007, may earn a bonus payment of 1.5% of their charges during that period, subject to a cap. CMS has titled the statutory program the 2007 Physician Quality Reporting Initiative (PQRI).

The purpose of this document is to give a high-level overview of our approach to 2007 PQRI implementation, as directed by the statute. Detailed program instructions, educational materials, and supportive tools will be posted as they become available on the CMS PQRI website at: http://cms.hhs.gov/PQRI. This overview of the 2007 PQRI will address: (1) eligible professionals, (2) quality measures, (3) form and manner of reporting, (4) determination of successful reporting, (5) bonus payment, (6) validation, (7) appeals, (8) confidential feedback reports, (9) transition from the 2006 Physician Voluntary Reporting Program (PVRP), and (10) 2008 considerations.

Eligible Professionals
TRHCA Section 101 defines “eligible professional” as the following:

1. Medicare physician, as defined in Social Security Act (SSA) section 1861(r):
    - Doctor of Medicine
    - Doctor of Osteopathy
    - Doctor of Podiatric Medicine
    - Doctor of Optometry
    - Doctor of Oral Surgery
    - Doctor of Dental Medicine
    - Chiropractor
2. Practitioners described in SSA section 1842(b)(18)(C):
    - Physician Assistant
    - Nurse Practitioner
    - Clinical Nurse Specialist
    - Certified Registered Nurse Anesthetist
    - Certified Nurse Midwife

- Clinical Social Worker
- Clinical Psychologist
- Registered Dietician
- Nutrition Professional

3. Therapists:
    - Physical Therapist
    - Occupational Therapist
    - Qualified Speech-Language Pathologist

All Medicare-enrolled professionals in these categories are eligible to participate in the 2007 PQRI, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims.

Quality Measures for Reporting

For 2007, TRHCA section 101 specifies that the quality measures for the PQRI shall be the "2007 physician quality measures under the Physician Voluntary Reporting Program as published on the public website of the Centers for Medicare & Medicaid Services as of the date of enactment of this subsection, except as may be changed … based on the results of a consensus-based process in January 2007 …." This provision refers to the list of 66 Physician Voluntary Reporting Program (PVRP) measures that CMS had posted on its website on December 5, 2006 (see Transition from 2006 PVRP section below). The list referred to in the statute was expanded based on actions approved at the January 22, 2007 AQA Alliance consensus process. The result is a final 2007 PQRI Quality Measures List, which is available at: www.cms.hhs.gov/PQRI, as a download from the Measures/Codes webpage.

In addition, the statute allows modifications or refinements, such as code additions, corrections, or revisions, to the detailed specifications for the measures included in the final 2007 PQRI Measures List until the beginning of the reporting period. The final 2007 PQRI Quality Measure Specifications will be available on the CMS PQRI website well in advance of the July 1, 2007 start date for the reporting period. The detailed specifications for each measure describe: (1) when that measure is reportable and (2) which quality-data code to report.

Prior to the July 1, 2007 start date, eligible professionals who plan to participate in 2007 PQRI should familiarize themselves and their office staff with the PQRI Quality Measures List and the specifications for each measure that applies to their patient populations.

Form and Manner of Reporting

TRHCA section 101 allows CMS to specify the form and manner of reporting. For 2007, we will be building on the claims-based quality reporting system implemented for the 2006 Physician Voluntary Reporting Program (PVRP), which ended December 31, 2006 (see Transition from 2006 PVRP section below). Participating eligible professionals whose Medicare patients fit the specifications of the 2007 PQRI quality measures will report the corresponding appropriate CPT Category II codes or G-codes (where CPT Category II codes are not yet available) on their claims. CPT Category II codes and G-codes are Healthcare Common Procedure Coding System (HCPCS) codes for reporting quality data. Claims-based reporting may be via: (1) the paper-based CMS 1500 Claim form or (2) the equivalent electronic transaction claim, the 837-P. Importantly, there is no need to enroll or register to begin claims-based reporting for 2007 PQRI.

The applicable CPT Category II code or G-code quality data must be reported on the same claim as the patient diagnosis and service to which the quality-data code applies. The analysis algorithms that determine successful reporting match the quality-data codes to the diagnosis, service, and procedure codes on the claim. Thus, quality-data codes that are not submitted on the same claim as the applicable patient diagnosis, service, and procedure codes will not count toward successful reporting or for calculation of a potential bonus payment.

Determination of Successful Reporting

The statutory description of satisfactory reporting depends on how many quality measures are applicable to the services furnished by the eligible professional during the entire reporting period of July 1-December 31, 2007. If there are no more than three quality measures applicable to the services provided by the eligible professional, then each measure must be reported for at least 80% of the cases in which the measure was reportable. If there are four or more quality measures applicable to the services provided by the eligible professional, then at least three measures, selected by the eligible professional, must be reported for at least 80% of the cases in which each measure was reportable.

The analysis of whether an eligible professional has successfully reported is expected to be performed at the individual eligible professional level using the individual-level National Provider Identifier (NPI). The eligible professional's individual NPI must be listed along with the HCPCS codes for services, procedures, and quality data on the claim. Thus, to participate in the 2007 PQRI, eligible professionals must have their individual-level NPIs and must consistently use their individual NPIs to correctly identify their services, procedures, and quality-data codes for an accurate determination of satisfactory reporting.

Eligible professionals select the quality measures that are applicable to their practices. If an eligible professional submits data for a quality measure, then that measure is presumed to be applicable for the purposes of determining satisfactory reporting. CMS recommends that eligible professionals report on every quality measure that is applicable to their patient populations to: (1) increase the likelihood that they will reach the 80% satisfactorily reporting requirement for the requisite number of measures and (2) increase the likelihood that they will not be affected by the bonus payment cap.

As detailed instructions, education, and tools to support successful claims-based reporting become available, they will be posted on the CMS PQRI website at: http://www.cms.hhs.gov/PQRI.

Payment for Reporting

Participating eligible professionals who successfully report as prescribed by TRHCA section 101 may earn a 1.5% bonus, subject to cap. The potential 1.5% bonus will be based on allowed charges for covered professional services: (1) furnished during the reporting period of July 1 through December 31, 2007, (2) received into the CMS National Claims History (NCH) file by February 29, 2008, and (3) paid under the Medicare Physician Fee Schedule. Because claims processing times may vary by time of the year and Medicare Carrier/Medicare Administrative Contractor (MAC), participating eligible professionals should submit claims from the end of 2007 promptly, so that those claims will reach the NCH file by February 29, 2008. Bonuses will be paid as a lump sum in mid-2008. There is no beneficiary co-payment or notice to the beneficiary regarding the bonus payments.

The bonus will apply to allowed charges for all covered professional services, not just those charges associated with reported quality measures. The term "allowed charges" refers to total charges, including the beneficiary deductible and copayment, not just the 80% paid by Medicare or the portion covered by Medicare where Medicare is the secondary payer. Note that the amounts billed above the physician fee schedule amounts for assigned and non-assigned claims will not apply to the bonus. The statute defines PQRI covered services as those paid under the Physician Fee Schedule only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a unique methodology. Other Part B services and items that may be billed by eligible professionals but are not paid under the Physician Fee Schedule, such as clinical laboratory services, pharmaceuticals billed by physicians, and Rural Health Center/Federally Qualified Health Center services, do not apply to the bonus.

A payment cap that would reduce the potential bonus below 1.5% of allowed charges may apply in situations where an eligible professional reports relatively few instances of quality measure data. Eligible professionals'

caps are calculated by multiplying: (1) their total instances of reporting quality data for all measures (not limited only to measures meeting the 80% threshold), by (2) a constant of 300%, and by (3) the national average per measure payment amount.

The national average per measure payment amount is one value for all measures and all participants that is calculated by dividing: (1) the total amount of allowed charges under the Physician Fee Schedule for all covered professional services furnished during the reporting period on claims for which quality measures were reported by all participants in the program by (2) the total number of instances for which data were reported by all participants in the program for all measures during the reporting period. (Note that the national average per measure payment amount calculation only takes into account the charges on claims for which quality measures were reported, whereas the individual bonus calculation takes into account charges for all services furnished during the reporting period.) Thus, while the purpose of the cap is clear, it is not possible to determine the impact of the cap until the national average per measure payment amount can be calculated after the end of the reporting period.

TRHCA section 101 specifies that for 2007, CMS must use the Taxpayer Identification Number (TIN) as the billing unit, so any bonuses earned will be paid to the TIN holder of record. Though the analysis of satisfactory reporting will be performed at the individual eligible professional level using individual-level NPI data (as discussed above in the Form and Manner of Reporting section), bonuses will paid to the holder of the TIN, aggregating individual bonuses for groups that bill under one TIN. For eligible professionals who submit claims under multiple TINs, CMS plans to group claims by TIN for payment purposes. As a result, a provider with multiple TINs who qualifies for the bonus payment under more than one TIN will receive a separate bonus payment associated with each TIN.

In situations where eligible professionals who are employees or contractors have assigned their payments to their employers or facilities, the statute specifies that any bonus payment earned will be paid to the employers or facilities.

Validation

TRHCA section 101 requires CMS to validate, using sampling or other means, whether quality measures applicable to the services furnished by a participating eligible professional have been reported. We plan to focus on situations where eligible professionals have successfully reported fewer than three quality measures. If CMS finds that eligible professionals who have reported fewer than three quality measures have not reported additional measures that are also applicable to the services they furnished during the reporting period, then CMS cannot pay those eligible professionals the bonus incentive payment.

Appeals

The statute specifically states that there shall be no administrative or judicial review of the determination of: (1) quality measures applicable to services furnished by eligible professionals, (2) satisfactory reporting, (3) the payment limitation or cap, or (4) the bonus incentive payment. However, CMS will establish a process for eligible professionals to inquire about these matters.

Confidential Feedback Reports

CMS will provide confidential feedback reports to participating eligible professionals at or near the time that the lump sum bonus payments are made in mid-2008. There will be no interim feedback during 2007. Quality data reported under the 2007 PQRI will not be publicly reported.

Access to confidential feedback reports may require eligible professionals to complete an identity-verification process to obtain a login identification and password for a secure interface. However, this process is not required to participate in the 2007 PQRI or to receive a bonus payment.

Transition from the 2006 Physician Voluntary Reporting Program (PVRP)
The 2007 PQRI will build on and replace the 2006 Physician Voluntary Reporting Program (PVRP), which was implemented as the first step toward pay for performance for physician services. For services provided to Medicare beneficiaries from January 1 through December 31, 2006, physicians were able to voluntarily report to CMS a starter set of 16 evidence-based performance measures that captured quality of care data. The data were collected via claims using CPT Category II codes and G-codes where CPT codes were not yet available. In December 2006, CMS provided confidential feedback reports containing reporting and performance rates to the physicians who had submitted performance data during the second calendar quarter of 2006. Though PVRP ended December 31, 2006, feedback reports for services provided during the third and fourth calendar quarters of 2006 will be made available during 2007.

2008 Considerations
For 2008, quality measures for eligible professionals must be proposed and finalized through rulemaking. According to the statue, the measures shall: (1) have been adopted or endorsed by a consensus organization, such as the AQA Alliance or National Quality Forum (NQF), (2) include measures that have been submitted by a physician specialty, (3) be identified by CMS as having used a consensus-based process for development, and (4) include structural measures, such as the use of electronic health records and electronic prescribing technology. The proposed 2008 quality measures set must be published by August 15, 2007 and finalized by November 15, 2007.

Though the short lead time for implementation of the 2007 PQRI will not allow us to offer registry-based or electronic health record-based reporting for 2007, we are exploring the use of these reporting mechanisms for 2008. We have already begun a series of meetings with representatives of physicians, medical boards, group practices, and therapists to discuss how CMS can promote the use of standardized specifications for centralized, electronic reporting.

Additional information is available on the CMS PQRI website at: http://www.cms.hhs.gov/PQRI or by contacting any Medicare Carrier/MAC.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5558.1	NOTE: This document is for educational purposes *only*.											

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5558.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin.	X		X	X							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Rachel Nelson, (410) 786-1175
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Post-Implementation Contact(s): Rachel Nelson, (410) 786-1175
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VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC),*** **use only one of the following statements:**
Funding for implementation activities will be provided to contractors through the regular budget process.

B. ***For Medicare Administrative Contractors (MAC)*****, use the following statement:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts alloted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.