



MEMORANDUM

To: Reporters and Editors
From: Dan Virkstis for Senate Finance Chairman Max Baucus (D-Mont.)
Jill Kozeny for Ranking Member Chuck Grassley (R-Iowa)
Re: Baucus, Grassley letter to acting CMS Administrator Kerry Weems

Senate Finance Committee Chairman Max Baucus (D-Mont.) and Ranking Member Chuck Grassley (R-IA) have outlined their intentions for improving Medicare payments for physician services by better linking those payments to the quality of care that is provided. In a letter this week, Senators Baucus and Grassley called on the Centers for Medicare and Medicaid Services (CMS) to implement the expansions and improvements to the Physician Quality Reporting Initiative (PQRI) enacted in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA).

Suggested enhancements include: (1) use of National Quality Forum-endorsed measures; (2) reporting on quality measure groups that focus on the care of patients with chronic conditions; (3) employing clinical databases to capture more complete information about physician quality; and (4) encouraging a team-approach to chronic care by permitting quality reporting by group practices.

“Everyone knows that our healthcare system needs reform. One of its greatest weaknesses is that we are paying for more and more medical services, without distinguishing between higher and lower quality care that patients receive,” said Baucus. **“By implementing these important changes to Medicare physician payments, we can continue to lead the way toward a system where patient outcomes are the paramount concern, and we get good value for our health care costs.”**

Grassley said, **“It only makes sense to reform the way Medicare pays doctors so that the system rewards the quality of care instead of the quantity of services provided. Congress started the ball rolling in 2006 with the incentives established that year in the Physician Quality Reporting Program for physicians to report consensus-based, quality measures to CMS. More good news came in December with passage of legislation that encourages broader participation in the program and provides new ways of ways of measuring and rewarding high quality care.”**

The Senators requested that CMS stay in close contact with the Finance Committee as the agency moves forward with PQRI for 2008.

The text of the Senators' letter follows here:

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January 23, 2008

Mr. Kerry Weems
Acting Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue
Washington, DC 20201

Dear Administrator Weems:

Ensuring that Medicare payments encourage providers to render high quality care to our nation's seniors is one of our highest priorities. For too long, our healthcare system, and specifically the Medicare program, has paid providers based solely on volume of services, creating incentives for higher resource utilization without regard to patient outcomes or quality of care.

The Physician Quality Reporting System established by section 101(b) of the Tax Relief and Health Care Act of 2006 (TRHCA), commonly known as the Physician Quality Reporting Initiative (PQRI), is a modest first step toward aligning Medicare physician payment incentives with high quality care. The Centers for Medicare and Medicaid Services (CMS) has implemented the PQRI program with great dedication, and this year, for the first time, clinicians will receive bonus payments for having successfully reported on quality measures in 2007. But our work to measure and pay more effectively for high quality care has just begun.

That is why, in section 101(b)(2)(B) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), we expanded and improved the PQRI program for 2008 and beyond. These improvements are designed to address existing shortcomings of PQRI, encourage broader participation by physicians and other eligible professionals, and move toward our long-term vision for a valid, consumer-friendly mechanism for measuring and rewarding the quality of care that clinicians provide.

First, MMSEA extended the 1.5 percent incentive payments for physicians who successfully report measures during 2008. The legislation removes the application of the cap on calculation of incentive payments for reporting in 2008 and 2009. We intend to move legislation that would extend incentive payments for 2009 and future years in order to continue making progress toward aligning Medicare payments more closely with the quality of care provided.

Second, as TRHCA required for 2008, MMSEA extended the requirement for CMS to specify a set of measures applicable for 2009. CMS should continue to expand and refine the PQRI quality measures for 2009. We envision additional extensions of this requirement so that the PQRI measure set will continue to improve in future years.

National Quality Forum (NQF)-endorsed measures are widely recognized as the gold standard for performance measurement. When CMS proposes a PQRI measure set for 2009, where NQF-endorsed measures are available for a given patient condition and meet any additional standards set by CMS, these measures should be adopted. For conditions where NQF-endorsed measures are not available, other consensus-based measures may be used, with the goal that appropriate NQF-endorsed measures would be used if they become available.

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It is important that CMS continue to work with NQF, the American Medical Association's Physician Consortium for Performance Improvement, specialty societies, and other stakeholders and measure developers to ensure that the most meaningful measures are available for use in PQRI. We also encourage the development of measures of patient outcomes, resource use, patient experience of care, and practice capabilities such as care coordination. Additionally, as PQRI evolves in subsequent years, we believe that greater focus should be placed on measures that assess higher levels of performance rather than adherence to minimum standards of competence.

Third, the existing PQRI reporting mechanism, whereby clinicians select up to three measures and report them on claims for at least 80 percent of relevant patient encounters, has generated strong interest among a broad array of clinicians, purchasers, and consumers. MMSEA extends the payment of bonuses for successfully reporting using this basic PQRI reporting mechanism for 2008. However, this methodology was intended to be a first step, and one of a number of potential alternatives for reporting and ultimately measuring performance. We believe that a more comprehensive approach to measuring and improving patient care can be accomplished by using a variety of methods.

One such alternative for reporting quality measures is to target groups of measures that focus on treatment of chronic conditions or preventive care. These measure groups could provide a more comprehensive view of patient care while targeting the aspects of our health care system that warrant the most urgent attention. Leaders in the performance measurement field have implemented the use of groups of measures for specific conditions, such as those targeting chronic illnesses like diabetes, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD).

Clinicians can report on their adherence to these groups of measures for a specified number of consecutive patients treated. Numerous studies demonstrate that these chronically ill patients require the greatest amount of health care resources yet receive in some cases the most inconsistent care across providers and regions.

MMSEA requires CMS to establish alternative criteria and alternative reporting periods for satisfactorily reporting groups of measures for specific conditions under PQRI. We encourage CMS to develop and implement this mechanism quickly for quality reporting in 2008. In implementing this approach, CMS should consider the experience of the National Committee for Quality Assurance (NCQA), NQF, the American Board of Medical Specialties (ABMS) and its member certifying boards, and others with expertise in this area.

Fourth, another method that has evolved in the field of performance measurement is utilizing clinical data registries to report on quality measures. TRHCA directed CMS to address the use of registries for PQRI in 2008, and the Agency has developed plans to pilot test models for this approach. MMSEA requires CMS to establish alternative criteria and reporting periods for satisfactorily reporting measures under PQRI via registries this year. The collection of data on quality measures through qualified registries should comport with the basic reporting requirements of PQRI.

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Specialty societies such as the Society of Thoracic Surgeons and the American College of Cardiology, a variety of integrated health systems, certain specialty-certifying Boards engaged in next-generation maintenance of certification programs, and NCQA are all examples of entities that could qualify as registries. We urge CMS to consider the experience of these and other organizations so that the Agency can begin to accept clinician performance data from valid registries this year and establish a strong foundation for registry reporting in subsequent years.

Physicians should be recognized and rewarded for registry-based reporting of performance data that combines information regarding Medicare, Medicaid, and other patients. This pooling of quality data from multiple payers is a vital component of accurate performance measurement and, ultimately, should lead to demonstrable quality improvement. Furthermore, by aggregating clinical rather than merely administrative data, leading registries can facilitate the sophisticated analyses needed to adjust performance measurement to account for variations in patient characteristics and accurately assess the quality of care clinicians provide.

Fifth, as another approach to measuring quality, CMS should take steps to allow physician group practices to employ a valid statistical sampling model to report performance data on an aggregate basis. Participating physician groups could report on specified measure sets that target high-cost chronic conditions using the approach CMS has developed in the Physician Group Practice (PGP) demonstration. The Agency should encourage these entities to document how their internal processes support performance measurement and improvement at the individual clinician level.

Group practices, especially multi-specialty group practices, promote enhanced care coordination and often deliver better patient outcomes. We know that these groups can thrive even in rural areas, including parts of Montana and Iowa. For future years, the Agency should develop the means of recognizing multiple physician network structures, including independent practice associations (IPAs) and physician-hospital organizations (PHOs), to continue to encourage better collaboration in treating patients with complex illnesses.

Finally, CMS should, in a user-friendly format, post on its website the names of clinicians and group practices that satisfactorily participate in PQRI. Patients deserve to know whether or not their caretakers have demonstrated this commitment to performance measurement and quality improvement. We intend to pursue additional statutory authority for this important step in upcoming legislation.

In conclusion, we thank you for being a committed partner in the effort to reform the way Medicare pays for physicians' services. We believe strongly that these enhancements to the PQRI program would substantially expedite the transformation of this payment system to one that better ensures high-quality, patient-centered care. Please contact [our staffs] as you move forward with PQRI for 2008.

Sincerely,

Max Baucus
Chairman

Chuck Grassley
Ranking Member

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