Participating in PQRI and Pay for Performance

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THE PHYSICIAN QUALITY Reporting Initiative (PQRI) began its second reporting period on January 1, 2008. This program from the Centers for Medicare & Medicaid Services (CMS) represents the agency's transition into pay for performance (P4P) and physician profiling.

Launched in July of 2007, the initiative has drawn relatively little physician attention. Many healthcare providers are unaware of the program's intent or design. While poor visibility has likely contributed to low participation, there are other factors to consider.

Many physicians are unfamiliar with the concepts of quality reporting and performance-based incentives - and the concepts themselves are rapidly evolving. Of providers aware of these trends, some hesitate to participate due to philosophical or logistical concerns.

We acknowledge arguments for and against the growing trend in performance-based incentive programs, and we encourage physicians to become informed and take part in the debate. Whether or not they participate in this round of PQRI or in similar programs, physicians need to be active stakeholders in efforts for increased quality and transparency in health care.

Medicare's Transition into P4P

PQRI is a voluntary program that allows physicians and other individual providers to submit data on specified quality measures for eligible patients. This initiative was mandated by the Tax Relief and Health Care Act of 2006 (TRHCA).[1] The initial reporting period was July through December 2007 and included 74 quality measures.

For the second reporting period, providers may select from 119 quality measures addressing the management of acute and chronic illness, preventative care, resource utilization, and use of information technology. The program is provider-driven, evidence-based and designed to capture data at the claims level. PQRI focuses on reporting measures rather than achieving clinical outcomes and is linked to a bonus payment for meeting reporting requirements.

PQRI is part of Medicare's transition into the P4P arena. The federal government and CMS have been moving toward a value-based purchasing (VBP) model of health care since 2001. This model attempts to measure and reward value. (Similar trends can be seen in

private industry, where cost-containment is arguably as much a motivation as is improved patient care.)

CMS identifies improving quality and avoiding unnecessary cost in health care delivery as primary goals of value-based purchasing.[2] Medicare's shift toward value-based purchasing is evident in several earlier CMS quality initiatives, including the Nursing Home Quality Initiative (in 2002), the Quality Initiative (2004), and the End Stage Renal Disease Quality Project (2005).[3]

PQRI and Individual Physicians

PQRI stands apart from these initiatives in that it focuses on data capture at the individual clinician level. Any physician or other eligible provider with a National Provider Identifier (NPI) may participate. From the outset, the program raises concerns regarding physician profiling, difficulty, acuity adjustments, and whether quality measures can ever be translated into meaningful information about patient care.

There are worries about a lack of transparency in the development of program specifics, the challenges of obtaining program information in a timely manner, and the impression that providers are required to do more work while being subjected to diminishing reimbursements.

Nonetheless, PQRI should not be dismissed. It can be argued that PQRI is, in terms of U.S. healthcare policy, a unique opportunity for providers to participate in reshaping the delivery and funding of medical care. It may be viewed as fair or unfair, elegant or burdensome, quality-driven or cost-motivated, temporary or permanent. However, PQRI allows participating providers to weigh in on the important issues of medical reimbursement, best practices, cost, outcomes measurement and resource use. Clinicians can contribute in this giant experiment in national healthcare data collection.

They do so by choosing measures which are relevant to their practices and patients, giving a good faith effort to report on those measures, providing feedback to CMS and related parties on the design and relevance of the measures, and publicly commenting on the value of the provider feedback reports and bonus awards. The development of a meaningful quality measurement system will require committed efforts from all stakeholders in health care, and it is extremely important that health care providers be involved.

Physician Profiling

CMS has been unapologetically increasing its efforts to identify and reward quality medical care. Inherent in its shift toward VBP is using tools and programs for promoting better quality while avoiding unnecessary costs. The agency notes that these include "explicit payment incentives to achieve identified quality and efficiency goals such as pay for reporting, pay for performance, gain-sharing, and competitive bidding." The programs mentioned earlier illustrate this effort.

PQRI is the first large scale CMS provider program. Participation involves reporting on selected measures using codes that indicate performance of certain clinical tasks or administration of therapies premised on evidence-based medicine. Included are mechanisms for clinicians to report without penalty when a clinical action has not been completed or documented.

With regard to the bonus, providers are measured on their level of reporting rather than directly on patient care, even though data on the latter are being captured. Presumably, this design allows for program revisions before actually attempting to measure and reward "performance" or "quality." In this way, PQRI is more accurately a "pay-for-reporting" than a pay-for-performance program.

While P4P programs in the public sector have focused on the hospital or organization level and are recently shifting to the individual provider, private industry has been using

them for decades. Many insurers have incentive programs that assign bonuses based on patient satisfaction surveys, laboratory values suggestive of effective disease management, and other proxy measures of clinician performance.

For example, Hill Physicians Medical Group paid $32 million in performance compensation to participating physicians in 2006, up from $13.5 million in 2003.[4] Similarly, Blue Cross of California announced a distribution of $69 million in physician bonus incentives in August 2007. [5]

Despite the increasing availability of performance and quality-related data, there is little to ensure the accuracy or proper use of such information. There are controversies surrounding the use of physician performance data, including lawsuits against third party payers.

A notable example is the suit filed in November 2006 by physicians and the Washington State Medical Association against Regence BlueShield. The plan was accused of unfairly dropping over 500 providers from its preferred network in that state due to poor ratings in the "quality and efficiency of their practices."[6] This policy allegedly affected over 8,000 patients and their physicians. The American Medical Association joined the case, and when Regence discontinued its use of a Select Network the following month, it was noted to be "a good first step toward eliminating arbitrary measures that do not accurately reflect physician quality."

Fortunately, the need for standardized measurement of provider performance is gaining recognition. While the debate on these issues will likely continue, we can expect to see more physician rating systems made public without guarantee that they will be fair or accurate.

While the landscape still offers relatively more ranking systems for hospitals and organizations (such as hospitalcompare.org, or healthgrades.com), individual physician profiling is clearly a growing phenomenon. Physician profiles are only useful if they are reliable and accurate, yet there is little research which demonstrates that existing programs are either.

This is largely due to a lack of standardization in quality data measurements. Few studies have been done which have the necessary adjustments for risk and large enough numbers of participating providers to produce useful data. The literature has yet to show that outcomes for patients can be consistently linked to measurements of physician actions in the clinical setting.

Clearly, for health care incentive programs including PQRI, the value of data depends ultimately on their translation into meaningful changes in practice. Inherent in this process is the capture of appropriate data and accurate interpretation, followed by the development and implementation of viable policies.

Using the Data

Assuming that the measures for PQRI 2008 address a fair sampling of clinical issues and corresponding appropriate clinical actions, there remains the question of how the data will be used. This is perhaps one of the greatest obstacles. In general, the data obtained may have a negative impact on physicians as an artifact of program structure, or it may be used to discourage clinical resource use.

Providers are also concerned that measures may fail to account for patient acuity, effectively penalizing those who take care of more ill and complicated patients. While acuity is being addressed in other CMS programs in the inpatient setting, it is not a factor in current assignments of the bonus in PQRI, and it remains unclear how the issue will be addressed in later iterations of the initiative.

Concerns about physician profiling, however, are both immediate and substantiated. The PQRI feedback reports will be provided directly to the practitioner in a confidential

manner for the 2007 and 2008 reporting periods, but it is expected that data in later years will be public domain. In the meantime, we have an opportunity for our profession to promote continuous quality improvement.

Physician profiling may seem inconsequential in the current environment, but the trend is toward increased profiling by payers and awareness by consumers. As a profession, our failure to participate in an objective and critical manner may leave us with misleading statistics and potentially damaging clinician rating programs.

On the other hand, participation in efforts to increase quality and high reliability in health care delivery can be empowering for practitioners and may lead to improved outcomes for our patients.

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