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***The Potential and Pitfalls of the Physician
Quality Reporting Initiative***

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I. INTRODUCTION

The mounting inertia for more pay-for-performance healthcare models provokes an obvious, but perplexing, question: how do we measure performance? Health and Human Services began responding to this question in 2001 when then-Secretary, Tommy Thompson, launched a Quality Initiative to determine how well healthcare providers performed and reported certain quality measures.¹ Not only did providers see how they compared to their peers, but patient-consumers were also able to access this information to make informed decisions when choosing a provider.² Then, in 2003, hospitals were given financial incentive to follow Medicare reporting measures for quality care through the Medicare Modernization Act.³ The well-regarded opinion that public reporting is a good

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¹ Sandra J. Tanenbaum, *Pay for Performance in Medicare: Evidentiary Irony and the Politics of Value*, 34 J. HEALTH POL. POL'Y. & L. 717, 720 (2009).

² *Id.*

³ *Id.*

strategy to measure and improve quality performance led to similar incentives.⁴

Public reporting holds the provider accountable by recording the steps taken to provide quality care while providing recognition for doing so, thereby yielding financial incentives, patient influx, or both.⁵

This article will address one such reporting system, the Physicians Quality Reporting Initiative (PQRI). The PQRI follows from a line of “Quality Initiatives” and has incorporated some of the successful aspects of other programs. The article will explain how the PQRI works as well as the successes and shortcomings reported thus far. Despite many mixed reviews about the program, many are hopeful that it will improve the quality of care provided by our healthcare system in the coming years.

II. THE BEGINNING OF THE PQRI

Authorized under the Tax Relief and Health Care Act of 2006, Centers for Medicaid and Medicare Services (CMS) followed Health and Human Services’ lead in 2007 by creating the PQRI.⁶ The PQRI is a payment incentive system for healthcare providers to receive financial benefits for meeting certain quality care thresholds, also known as benchmarks, when treating Medicare patients.⁷ When first launched, physicians earned up to a 1.5% bonus payment on their allowed

⁴ *Id.*

⁵ *Id.*

⁶ Timothy Cahill, *The 2007 Physician Quality Reporting Initiative: Will it be a Significant Step in the Move Toward Pay-for-Performance*, 19(7) THE ABA HEALTH LAW SEC.: THE HEALTH LAW. 1, 1 (2007).

⁷ Brett Elliott, *To Participate or Not in the Physician Quality Reporting Initiative (PQRI); That is the Question*, 79(5) DEL. MED. J. 197, 197 (2007).

Medicare charges by reporting on up to seventy-four different quality measures.⁸ In 2010, the bonus increased to 2%,⁹ and the number of quality measures expanded to 179.¹⁰ It is important to note that, despite the name, the PQRI applies to a broad range of healthcare providers, including physicians, dentists, chiropractors, registered dietitians, clinical social workers, and other allied health professionals.¹¹ The quality care benchmarks are established by an array of medical agencies, such as the American Medical Association and the Physician Consortium for Performance Improvement, along with input from other organizations regarding benchmarks particular to their specialty.¹²

CMS instituted the PQRI after the relative success of its Hospital Quality Incentive Demonstration program, in which 270 hospitals reported on quality measures in five clinical areas from 2003 to 2006.¹³ CMS provided bonuses to the top performers and reduced payments to the lowest performers.¹⁴ Even though the data available for analysis was somewhat limited, CMS did report a 6.6% improvement rate in overall quality of care.¹⁵ However, not all of CMS's past quality initiatives were successful. The PQRI came in the wake of CMS's Physician Voluntary Reporting Program in 2006, which was not as successful as

⁸ Latanya Sweeney, *The Medical Billing Framework as the Backbone of the National Health Information Infrastructure 2* (Carnegie Mellon Univ., Working Paper No. 1001, 2009), available at <http://advancehit.org/publications/p1001/AdvanceHIT1001.pdf>.

⁹ Ctrs. for Medicare & Medicaid Servs., Physician Quality Reporting Initiative: Overview, http://www.cms.hhs.gov/pqri/01_Overview.asp (last visited Feb. 26, 2010) [hereinafter *Physician Quality Reporting*].

¹⁰ CTRS. FOR MEDICARE & MEDICAID SERVS., 2010 PQRI MEASURES LIST 1 (2009), available at http://www.cms.hhs.gov/PQRI/Downloads/2010_PQRI_MeasuresList_111309.pdf [hereinafter MEASURES LIST].

¹¹ Elliott, *supra* note 7, at 197.

¹² *Id.* at 197-98.

¹³ Tanenbaum, *supra* note 1, at 721.

¹⁴ *Id.*

¹⁵ *Id.*

anticipated.¹⁶ This program, unlike the PQRI, did not have many participants for two main reasons: lack of financial incentive and burdensome reporting methods.¹⁷

CMS learned from their missteps in past programs and made PQRI relatively easy to follow and provided financial incentives as well. Every quality measure requires a specific clinical action that may be related to prevention, management of chronic care condition, management of acute episodes of care, resources utilization, or care coordination.¹⁸ An example of a quality measure is the percentage of patients who are age sixty-five or older and were screened over the past year for future fall risks.¹⁹ Each measure also has a reporting frequency requirement. In other words, certain measures may only need to be recorded one time, whereas other measures may need to be recorded for each test of certain conditions.²⁰ For instance, the previous example of screening for future fall risks in seniors must be recorded once a year.²¹

III. FEATURES OF THE PQRI

The PQRI provided performance modifying measures for the inescapable exceptions to the rules set out above.²² There may be reasons when a clinical action required by the rules may not be taken. For instance, the patient could have already received the needed care from another healthcare provider or there

¹⁶ Cahill, *supra* note 6, at 1.

¹⁷ *Id.*

¹⁸ *Id.* at 3.

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

could be a potential adverse drug interaction.²³ In addition to medical reasons for not following PQRI protocol, the provider may also report when a patient declines prescribed care for social, economic, religious, or other personal reasons.²⁴ This is an important feature of the PQRI because it applies real world circumstances to potentially static laws. Through these performance modifying measures, physicians are not penalized for non-compliant patients or patients who require care that does not coincide with the traditional treatment methods and preventative care established by the PQRI.²⁵

Typically, not all 179 quality measures will apply to every healthcare provider given the breadth of health conditions the PQRI covers, which include conditions ranging from diabetes to prostate cancer to cataracts.²⁶ Therefore, all eligible providers select which measures are relevant to their practice and prepare reports for their applicable Medicare patients.²⁷ For instance, if no more than three quality measures apply to an eligible provider, the PQRI mandates that each measure be reported in 80% of the cases in which the measure could have been reported.²⁸ If more than three quality measures apply to a provider, 80% of the relevant cases still must still be reported in at least three of the measures.²⁹

The percentage is derived from a numerator, the clinical action required by the measure and quantified by a quality data code, and a denominator, the pool of eligible patients that would benefit from the action, associated with each quality

²³ *Id.*

²⁴ *Id.*

²⁵ Elliott, *supra* note 7, at 198.

²⁶ MEASURES LIST, *supra* note 10.

²⁷ Cahill, *supra* note 6, at 3.

²⁸ *Id.* at 4.

²⁹ *Id.*

measure.³⁰ The percentage is finally calculated by analyzing the numerators and denominators and comparing when a measure was actually reported to when the measure could have been reported.³¹ Once it is determined that the eligible provider successfully reported 80% of Medicare cases for the requisite quality measures, the provider is eligible for a bonus payment of 2% on the allowed charges for all covered Medicare services, not just services affiliated with the reported quality measures.³² The bonus amount is subject to a cap that is determined at the end of the PQRI reporting cycle.³³ The PQRI is completely voluntary, and eligible providers only need to submit their quality data codes to be considered for the Medicare bonus payment.³⁴

IV. POTENTIALS AND PITFALLS

While this approach is logical, it presents some logistical difficulties. Such difficulties are particularly pronounced in group practices electing to participate in the PQRI because CMS pays the bonuses to the holder of the group Tax Identification Number (TIN) as required by § 1848(m)(3)(C)(iii) of the Social Security Act.³⁵ A group practice holds the TIN, thus making individual providers in the group ineligible for receiving separate bonuses through the PQRI.³⁶ Thus, the CMS reporting measure bonuses will be aggregated to the group as opposed to

³⁰ *Id.*

³¹ *Id.*

³² *Physician Quality Reporting*, *supra* note 9.

³³ Cahill, *supra* note 6, at 4.

³⁴ Elliot, *supra* note 7, at 202.

³⁵ Ctrs. for Medicare & Medicaid Servs., Physician Quality Reporting Initiative: Group Practice Reporting Option, http://www.cms.hhs.gov/PQRI/22_Group_Practice_Reporting_Option.asp#TopOfPage (last visited Feb. 26, 2010).

³⁶ *Id.*

the individual providers.³⁷ Since all of the PQRI data is aggregated for group practice,³⁸ the decision of whether or not to even participate may be a source of contention among group practitioners.

Furthermore, the manner in which the pool of eligible patients is derived presents difficulties for practices that do not have electronic medical records (EMR). In fact, although 40% of physicians utilize EMRs in their offices in 2008 and 2009, only 7% were considered fully functional.³⁹ Some EMR systems may only provide demographic information,⁴⁰ which is not sufficient to report on PQRI quality measures.⁴¹ For instance, in the example of screening patients age sixty-five and older for future fall risks, most practices that utilize a limited EMR system could generate a list of those patients based on demographic information. But since the PQRI only applies to Medicare patients, such systems are insufficient as they merely generate a large patient pool that must still be sifted through to find Medicare patients. Some physicians argue that reporting tasks are manageable by simply adding the quality code to Medicare claims that healthcare providers already use in everyday practice.⁴² While this would be an improvement over sifting through individual patient's charts, it would still be an

³⁷ *Id.*

³⁸ *Id.*

³⁹ Marianne Kolbasuk McGee, *Many Doctors Already Using E-Medical Records*, INFORMATIONWEEK, Jan. 13, 2010, <http://www.informationweek.com/story/showArticle.jhtml?articleID=222300536>.

⁴⁰ *Id.*

⁴¹ Stinson Paul, *The PQRI Catch-22: The CMS 1.5 Percent Reimbursement May Incentivize IT Adoption, but Will It Do so Equally, and Is It Enough?*, ALLBUSINESS, Oct. 1, 2007, <http://www.allbusiness.com/insurance/health-insurance-government-health-medicare/5504694-1.html>.

⁴² Elliott, *supra* note 7, at 203.

arduous task to go through all Medicare claims to determine whether or not a condition was reported and whether or not it should have been reported.

Another reporting option available to providers is the use of an independent, PQRI-approved registry.⁴³ These registries compile information from participating providers and generate quality measure results that they then submit to CMS.⁴⁴ An organization may qualify as a registry if it meets several requirements promulgated by CMS; including at least twenty-five participants, not owned or managed by an individual locally-owned single-specialty group, and the ability to collect all the data necessary to calculate compliance of the PQRI benchmarks.⁴⁵

In addition to reporting difficulties, the results of the quality measures are difficult to quantify. Not only does the PQRI focus only on Medicare patients, but also, the quality benchmarks focus only on process indicators as opposed to outcome indicators.⁴⁶ This protocol means that, although the ordered tests and referrals are factored into quality measures, the result of treatment and patient follow-up is not incorporated.⁴⁷ While this method seems insufficient, objective outcome indicators are difficult to measure. For example, at what point does a physician reach the benchmark for treating a patient with a terminal illness? Is it after a patient's life is extended for several months after diagnosis? Several

⁴³ CTRS. FOR MEDICARE & MEDICAID SERVS., REGISTRY REQUIREMENTS FOR SUBMISSION OF 2010 PQRI DATA ON BEHALF OF ELIGIBLE PROFESSIONALS 1 (2009), *available at* [http://www.cms.hhs.gov/PQRI/Downloads/2010RegistryRequirementsFinal_1\(2\).pdf](http://www.cms.hhs.gov/PQRI/Downloads/2010RegistryRequirementsFinal_1(2).pdf).

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ Elliott, *supra* note 7, at 198.

⁴⁷ *Id.*

years? Should the quality of life factor into the benchmark, and how can it be measured?

Moreover, the absence of outcome benchmarks safeguards healthcare providers against non-compliant patients.⁴⁸ Rightly, physicians should not be penalized for a lack of patient follow-up; however, at the same time, physicians should be held accountable for failing to follow-up with their patients. The healthcare agencies involved in the PQRI need to determine the appropriate follow-up measure for physicians, such as a phone call to discuss test results or a postcard reminding the patient to schedule a follow-up appointment.

V. CONCLUSION

Moving forward, it is important for the PQRI to continue its tradition of receiving input from the medical community in formulating new requirements and recommendations. According to Dr. David Cutler, one of President Obama's health advisors, "if a [payment] system is just imposed on doctors. . . it will be a disaster."⁴⁹ Cutler emphasizes that there is a need for physicians to buy-in for healthcare reforms to succeed.⁵⁰ In contrast, the current payment system penalizes physicians for spending extra time with patients, but the system would benefit from incorporating widely accepted quality measures with input from practicing physicians.⁵¹ Hopefully, the historical input of health agencies into the

⁴⁸ *Id.*

⁴⁹ Mark Crane, *Obama Chief Health Advisor Pushes Pay for Performance if Doctors Like Standards*, MEDPAGE TODAY, Mar. 14, 2008, <http://www.medpagetoday.com/Washington-Watch/Washington-Watch/8743>.

⁵⁰ *Id.*

⁵¹ *Id.*

PQRI quality measures will encourage the implementation of quality measures that healthcare providers will support and incorporate into their everyday practice.

The PQRI, like other healthcare reform models, is far from perfect. The current CMS Fee Schedule tends to reward providers for the quantity of patients' physicians and the resources consumed, rather than the quality of the visit or the value of such services to the patient.⁵² While the PQRI seeks to improve the quality of care, it has limited applications and must be studied in context. The biggest drawback is that the PQRI only applies to Medicare patients. As this demographic grows exponentially in the coming decades, the PQRI may prevent an accurate assessment of quality measure reporting for the entire patient population.

Another shortcoming is that the PQRI only reports on process indicators and not the actual outcomes of treatment.⁵³ While outcome indicators are difficult to quantify, it is important to assure that patients are benefiting from these quality measures. The lack of reporting on the patients' health status challenges the effectiveness of the model and its benefit to the general population. Also, most healthcare providers do not have the necessary EMR technology available to utilize easier reporting methods.

When the PQRI was first instituted, the acting CMS Administrator, Leslie V. Norwalk, Esq., stated:

[T]he Medicare program needs to compensate physicians appropriately for the services they provide to people with Medicare. But how the program pays also matters. We think the early work on the PQRI program is one of those reforms

⁵² Cahill, *supra* note 6, at 1, 3.

⁵³ Elliott, *supra* note 7, at 198.

that could help lead us to a point where we can promote better quality care and more efficient care.⁵⁴

Norwalk's optimistic outlook is shared by many in the healthcare community. Many benchmarks remain to be met with PQRI; namely, whether there was an actual improvement in patients' health due to these quality measures and what the implication is for the general population. Once all of the PQRI benchmarks are met, and with the increasing use of EMR to assist in reporting, the PQRI has the potential be to an effective model for the entire U.S. healthcare system.

⁵⁴ Cahill, *supra* note 6, at 5-6.