HEALTH CAPITAL Topics

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Improving Quality through Physician Rankings, P4P and Patient Safety Organizations

Two recent studies on the success of *pay-for-performance* (P4P) programs have shown that there is a correlation between such programs and *higher quality* of care for patients. The study conducted by CMS and Premier, Inc., called the "*Hospital Quality Incentive Demonstration"* (HQID), measured cost and quality improvements among P4P providers for five different patient populations: pneumonia, coronary artery bypass graft, congestive heart failure, acute myocardial infarction/heart attack, and hip and knee replacement. The study, which was begun in 2003, has impressively concluded that "*if all hospitals nationally were to achieve the three-year cost and mortality improvements found among the HQID project participants for [the five different patient populations], they could save an estimated 70,000 lives per year and reduce hospital costs by more than $4.5 billion annually*."[1]

A second study, conducted by researchers from UCLA and supported by the Hawaii Medical Service Association in Honolulu, also showed improved quality of care among P4P providers in *preferred provider organization* (PPO) settings, as well as an increased number of patients going to P4P physicians.[1] The study analyzed 11 quality indicators for patients enrolled in PPOs over six years, and found that the patients who visited only physicians who were participating in the study had significantly higher odds of receiving recommended care as measured by the indicators.

Additionally, CMS recently released a list of 119 "*clinical performance measures*" designed to improve quality as part of the *Physician Quality Reporting Initiative* (PQRI), which "*creates a quality reporting system that includes an incentive payment for satisfactorily reporting data on quality measures for covered professional services delivered to Medicare beneficiaries.*"[1] Under the PQRI, participating physicians who report quality data on covered professional services provided in 2007 will receive incentive payments in 2008, amounting to 1.5% of their total charges for covered services during the reporting period. According to CMS, more than half the physicians who reported in 2007 are eligible to receive the 2008 incentive payment, and CMS expects the number of physicians participating in the PQRI to increase in the future. Although the incentive payment is intendedto improve quality, the payment encourages physicians to maintain their practices within the scope of the PQRI quality measures, thereby raising the potential for physicans to feel pressure to choose less costly diagnoses. Consequently, Although P4P programs and the PQRI are intended to improve quality, it is questionable whether there will still be too much focus on cost being an element of the quality of care. In response to this concern, *d*physicians and national health insurers have developed an external plan to *rank physician performance* that works for both parties, and will hopefully address physicians 'concerns that the previous ranking systems were too focused on cost of care. While insurers say that they will abide by the agreement to rank physicians based on *both* cost and quality of care, the ranking system has not yet been implemented, so no actual standards have been decided upon. However, to add more *transparency* to the ranking process, the insurance companies will allow the rankings to be reviewed by independent parties. The new standards are intended to allow for *uniformity* in rankings between different insurers, which will allow patients to better review and compare different doctors, thereby further increasing transparency.[1]

The increased focus on quality of care is related to how hospitals and doctors deal with patient safety and adverse events. On the topic of patient safety, federal regulators have issued rules that would finally implement the *Patient Safety and Quality Improvement Act of 2005* (PSQIA). This Act authorizes the creation of *patient safety organizations* (PSOs) which would be *confidential depositories* of information on mistakes and adverse events. AMA Trustee J. James Rohack, M.D., believes that the legislation "*will allow health care professionals to report errors voluntarily without fear of legal prosecution and transform the current culture of blame and punishment into one of open communication and prevention.*"[1] Similarly, to reinforce this positive outlook, the rules would prevent health insurers from becoming PSOs.

The PSOs would represent *national quality review standards*, thereby creating *uniform protections* from state to state. Even though original data existing apart from patient safety reports is still discoverable in litigation, anything actually reported to a PSO, or the deliberations taken by hospital administration to decide

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whether to report a "near miss," would be protected from subpoena. Since providers have been traditionally wary of releasing information about medical errors for fear that it will be used against them in tort actions or disciplinary proceedings, it is still questionable as to whether the new rules would do enough to protect providers from liability. As a result, it is likely that the HHS Agency for Healthcare Research and Quality will extend the comment period on the new provisions from six months to one year.

There is an interesting intersection between the studies of the successes of P4P programs and physician rankings on one hand, and the implementation of the PSQIA on the other. All three represent part of what has been called the "*hydra-headed*" quality issue.[1] On the one hand, P4P only works if there is a significant level of transparency between a physician and patient so that the patient may make informed decisions about which doctor to choose based on quality and cost. That transparency, in turn, comes somewhat from physician ranking schemes. On the other hand, the PSQIA makes all information that is reported confidential and preventing potential patients from having access to the information about physician errors. However, ithis type of disclosure is a form of transparency to groups that would eventually advocate for the patient's rights, thereby improving quality through better, even if not complete, transparency.

Above all, as Stephanie W. Kanwit, special counsel to America's Health Insurance Plans in Washington, has stated, "*Promoting quality improvement has to be grounded on the concept of an 'informed consumer' There's truly a ground swell, both public and private, for greater transparency*."[1] Transparency is clearly one of the most important issue facing providers and hospitals today and it is this transparency that is driving up quality, not only through physician ranking systems, but also through P4P programs and initiatives.

[1] "Hospital quality improving, cost, mortality rate trends declining for participants in Medicare pay-for-performance project," Press Release, By Alven Weil, Premier Inc. Website, January 31, 2008, http://premierinc.com/about/news/08-jan/performance-pays-2.jsp (Accessed April 25, 2008).

[1] "Patient outcomes and evidence-based medicine in a preferred provider organization setting: a six-year evaluation of a physician pay-for-performance program," Amanda S. Gilmore, et al, 42 Health Services Research 2140 (Dec. 2007, http://findarticles.com/p/articles/mi_m4149/is_6_42/ai_n21157693/print (Accessed April 21, 2008).

[1] "Quality Reporting Initiative Will Help Improve Health Care for Beneficiaries and Provide Incentives for Eligible Professional," Centers for Medicare and Medicaid Services, Press Release, April 17, 2008, http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3047 (Accessed April 17, 2008).

[4] "Insurers Agree to Develop a Set of Standards in Rating Doctors," By Reed Abelson, *The New York Times*, April 1, 2008, http://query.nytimes.com/gst/fullpage.html?res=9C05E0D61338F931A35757C0A96E9C8B63&scp=1&sq=physician+rank&st=nyt (Accessed April 25, 2008).

[5] "Rules aim for better patient safety through confidential error reports," By Dave Hansen, *American Medical News*, March 10, 2008, pg 1.

[6] BNA Health Law Reporter, "Outlook 2008: Health Care Quality, Fraud and Abuse Top List of Health Law Issues for 2008," Vol. 17, No. 1, Jan. 3, 2008, pg 5 (quoting Thomas W. Mayo, of counsel to the firm of Haynes and Boone LLP, Dallas, Texas).

[7] BNA Health Law Reporter, "Outlook 2008: Health Care Quality, Fraud and Abuse Top List of Health Law Issues for 2008," Vol. 17, No. 1, Jan. 3, 2008, pg 5.

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