

# Grading a Physician's Value — The Misapplication of Performance Measurement

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Perhaps the only health policy issue on which Republicans and Democrats agree is the need to move from volume-based to value-based payment for health care providers. Rather than paying for activity, the aspirational goal is to pay for outcomes that take into account quality and costs. In keeping with this notion of paying for value rather than volume, the Affordable Care Act (ACA) created the “value-based payment modifier,” or “value modifier,” a pay-for-performance approach for physicians who actively participate in Medicare. By 2017, physicians will be rewarded or penalized on the basis of the relative calculated value of the care they provide to Medicare beneficiaries.

Although we agree that value-based payment is appropriate as a concept, the practical reality is that the Centers for Medicare and Medicaid Services (CMS), despite heroic efforts, cannot accurately measure any physician's overall value, now or in the foreseeable future. Instead of helping to establish a central role for performance measurement in holding providers more accountable for the care they provide and in informing quality- and safety-improvement projects, this policy overreach could undermine the quest for higher-value health care. Yet the medical profession has been remarkably quiet as this flawed approach proceeds.

The value modifier is meant to provide differential payment to

a physician or physician group under the Medicare Physician Fee Schedule on the basis of the quality of care furnished as compared with the cost; it will result in a reward or penalty amounting to 1 to 2% of payments for groups of 100 physicians or more in 2015 and for all physicians by January 1, 2017. CMS anticipates increasing the percentage of payments at risk as positive experience accrues. To reduce the burden on physicians, CMS has based the value modifier on the Physician Quality Reporting System (PQRS).

The PQRS has been in place since 2007. It now consists of more than 200 measures, mostly of recommended clinical processes, prevention, and care coordination. The measures are spread across the dozens of specialties and subspecialties that serve Medicare patients, and so only a handful apply to any individual health care professional. After 6 years, and despite being offered various ways to report quality data (by means of a Web interface, registries, and administrative claims), less than 30% of eligible professionals actually report their data to CMS.

This dismal participation rate by physicians contrasts markedly with hospitals' participation levels, which are higher than 99% in the comparable pay-for-reporting and pay-for-performance programs that CMS administers. The different participation rates are a result of the different economics of hospitals and physician practices. Hospital margins are typically

in the low single digits; 1 to 2% more or less is a big deal. Physician practices have overheads of 55 to 60%; the rest is available for physicians to take home or invest in practice improvements. Here, 1 to 2% is a small deal. Furthermore, under a fee-for-service system, physicians can usually generate more reimbursable patient services and sometimes up-code their services in reporting them to make up for any small revenue shortfalls, while avoiding the substantial costs of reporting on the PQRS quality measures.<sup>1</sup>

The meager rate of physician participation in the PQRS also suggests that something is fundamentally wrong — physicians simply do not respect the measures, and for good reason. PQRS measures reflect a vanishingly small part of professional activities in most clinical specialties. A handful of such measures can provide a highly misleading snapshot of any physician's quality. Research shows that performance on specific aspects of care does not predict performance on other components of care. Primary care physicians manage 400 different conditions in a year, and 70 conditions account for 80% of their patient load. Yet a primary care physician currently reports on as few as three PQRS measures.

One definition of physician professional competence is “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection

in daily practice for the benefit of the individual and the community being served.”<sup>2</sup> Patients place emphasis on physicians’ confidence, empathy, humanity, personability, forthrightness, respect, and thoroughness.<sup>3</sup> A global measure of value should capture most, if not all, of these diverse elements of desired performance. Yet available measures in the PQRS and elsewhere are relevant to few of these professional qualities.

***To reduce the burden on physicians, CMS has based the value modifier on the Physician Quality Reporting System (PQRS). But physicians do not respect the PQRS measures, and for good reason: they reflect a vanishingly small part of professional activities in most clinical specialties.***

More concretely, examples of important but mostly overlooked aspects of physician performance that we would want to measure include making accurate and timely diagnoses, avoiding overuse of diagnostic and therapeutic interventions, and caring for the growing number of patients with multiple chronic conditions and functional limitations.<sup>4</sup> A radiologist’s primary role is to provide accurate and complete interpretations of imaging studies. Yet because we lack measures of accuracy for radiographic diagnoses, PQRS measures include “exposure time reported for procedures using fluoroscopy” and “inappropriate use of ‘probably benign’ assessment category in mammography screening.” The PQRS is predicated on the dubi-

ous proposition that measuring and rewarding performance on such obscure clinical aspects of care is worthwhile. Even if such activities are beneficial, performance on these measures is not indicative of a radiologist’s quality as part of the CMS value calculation.

Consider quality for surgeons. We want to be able to measure performance on core competencies that affect outcomes, such

as judgment about whether and when to operate and which procedure to use, as well as the surgeon’s technical skill in the operating room. Yet because these characteristics are difficult to quantify accurately and routinely, PQRS measures for surgeons instead include adherence to guidelines for antibiotic and anticoagulation prophylaxis. Again, these measures assess worthy prevention activities but do not reflect a surgeon’s contribution to producing value.

The challenge of accurately assigning costs to an individual physician is similarly daunting. Current methods for case-mix adjustment do not adequately capture variations in patients’ illness severity, complicating coexisting conditions, or relevant socioeco-

omic differences — differences beyond the physician’s control that affect the cost of care. And we currently don’t know how to attribute to an individual physician the costs that Medicare beneficiaries generate across the health care system.

In essence, policymakers are caught in a difficult dilemma. Current measures provide misleading assessments of value, but to actually influence physicians’ behavior, we need to increase pay-for-performance incentives above the current Medicare level of 1 to 2%. As the classic Catskills joke goes, “The food here is plain poison, and such small portions!”

Even if we had better measures, behavioral economists would still challenge the pay-for-performance concept, at least for professionals such as physicians and teachers, who must manage complex situations and creatively solve problems. These critics argue that rewarding professionals on the basis of a particular performance measure has the potential to crowd out the intrinsic motivation to perform well across the board, not just on the few activities being measured.<sup>5</sup>

Many physicians will ignore the value modifier as they have ignored the PQRS, accepting the small financial losses. To an individual physician, adoption of the flawed value modifier may currently appear trivial, but the negative downstream effects on health care delivery and the future increases in rewards and losses make the modifier an issue that should not be ignored. Adopting the flawed value modifier could undermine the ACA’s more worthy approaches to improving health care value, such

as changing the unit of accountability from individual physicians to the organizations to which they belong, changing payment methods to encourage more prudent use of resources, and using quality measures more selectively and strategically, as CMS is doing by requiring accountable care organizations (ACOs) to meet particular quality measures that are central to ACOs' missions before they are allowed to pocket savings from reducing spending. Quality measurement can play an important role in Medicare, but the

value-based payment modifier is the wrong way to apply it.

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