

The Physician Quality Reporting Initiative: Implications for Rural Physicians

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Pay-for-performance (P4P) and pay-for-reporting (P4R) programs, which align provider payment with quality of health care, have become increasingly popular in the United States since the Institute of Medicine released its 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. In P4P programs, providers receive incentives for improving performance with respect to quality goals or targets, while in P4R initiatives providers receive incentives for reporting quality data, though they need not demonstrate improvements in outcomes. Many performance improvement initiatives have focused on large health care entities, such as hospitals, but considerable uncertainty remains regarding how to best design and implement these programs in physician practices, especially within rural communities.

This study explored the design and implementation of a P4R program, the Physician Quality Reporting Initiative (PQRI), in order to identify the implications for rural physicians. Authorized in December 2006 under the Tax Relief and Health Care Act of 2006 (TRHCA), PQRI is the Centers for Medicare and Medicaid Services' (CMS) first nationwide initiative to provide physicians with incentives to report quality data. Physicians and other eligible professionals who successfully report quality data to CMS related to covered services provided under the Medicare Physician Fee Schedule could earn a bonus payment. In 2007, the bonus payment was subject to a cap of 1.5% of total allowed charges for covered Medicare services. Physicians who choose to participate must satisfactorily report data on at least three measures for at least 80 percent of the cases in which the measure was applicable. In 2007, eligible professionals chose from 74 quality measures. According to CMS, participating in PQRI is a way to prepare for future P4P programs.

This study assessed whether there are any unique opportunities or challenges related to participating in the 2007 PQRI that would be systematically different for rural versus urban primary care physicians. Findings are based on a literature review and feedback from ten representatives from state medical societies and medical practices that have participated in PQRI.

KEY FINDINGS

- Rural practices may be at a disadvantage with respect to participating in the Physician Quality Reporting Initiative (PQRI) – not necessarily because of their geographic location, but because they tend to be smaller, and have fewer resources and a less developed quality measurement infrastructure.
- The PQRI incentive payment was widely considered insufficient to incentivize primary care physicians to participate in PQRI if they did not have staff and systems to support quality reporting.
- Rural practices that did not receive the incentive payment and/or did not receive adequate feedback may be less likely to participate in PQRI in the future.
- Medical societies are engaging with their members about PQRI on a limited basis, but could serve as a useful mechanism to disseminate educational information about PQRI.

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Methods

This study consisted of a literature review to explore rural physicians' experiences in P4P and P4R programs and key informant interviews with representatives from state medical societies and medical practices that have participated in PQRI. The intent of both study components was to explore the implications of PQRI for rural primary care physicians.

In the first phase of the study, NORC examined the published and unpublished literature on P4P and P4R programs and reviewed documents focused on rural providers. Few studies were identified that addressed P4P or P4R programs in the context of rural practice.

In the second phase, NORC conducted key informant interviews with representatives from state medical societies and medical practices that participated in PQRI. Study findings are based on information from a total of ten respondents representing seven states. Semi-structured telephone interviews were conducted with five state medical society representatives. NORC also received written correspondence regarding our research questions from two additional state medical society representatives. In order to build upon the findings from our interviews with medical society representatives, we conducted interviews with a total of four representatives from medical practices in four states that participated in PQRI. One of the medical practice representatives was also a medical society representative.

To ensure that a variety of perspectives were collected, key informants were selected from states that were classified as urban or rural, based on the percent of each state's population residing in rural areas using U.S. Census 2000 data. States in the 1st and 4th quartiles were classified as most rural and least rural, respectively. States were also classified as high or low reporting, depending on the percentage of eligible providers in the state who participated in the PQRI program by submitting quality data. The classification of high and low reporting states was based on preliminary 2007 CMS data accessed on our behalf by PQRI experts from the Senate Finance Committee. Of the most rural states, we selected two that were "high reporting" (Vermont, North Dakota) and two that were "low reporting" (Arkansas, Montana). Of the most urban states, we selected two that were "high reporting" (Florida, Illinois) and two that were "low reporting" (Hawaii, New York). We recruited medical society and medical practice representatives in the selected states.

Interview questions encompassed the following topic areas: factors that affect rural primary care physicians' decisions to participate in PQRI; challenges or opportunities related to participating in P4P or P4R programs that would be systematically different or challenging for rural versus non-rural primary care physicians; the impact of a practice's case mix on participation; and recommendations to improve participation in PQRI.

While it was our intention to focus on primary care physicians' experiences participating in PQRI, the feedback from medical society representatives may have related

to other types of providers as well. It is unclear whether there are systematic differences between primary care and specialty practices that would lead this broader feedback to be less representative of primary care. Additionally, while respondents were asked to share their experiences with the 2007 PQRI, it is possible that they commented on their experiences with PQRI in subsequent years.

Semi-structured interviews were conducted allowing subjects to respond conversationally to open-ended questions. Interviews were typically 30 to 45 minutes in length and were conducted by phone between October 2008 and January 2009. Several key themes emerged and are described in the following sections.

Primary Care Physicians' Participation in PQRI

Respondents from state medical societies believed that few primary care physicians serving rural communities currently participate in PQRI. Interviews revealed that medical societies are engaging with their members about PQRI on a limited basis, but could potentially serve as a useful mechanism to disseminate PQRI educational information. Representatives from medical societies currently distribute PQRI information to their members via weekly newsletters, information on the society's website (e.g., live presentations, interactive seminars), webinars and calls, and member hotlines. While none of the medical societies discourage members from participating in PQRI, only two out of seven actively encourage participation. None of the medical society representatives knew the proportion of their membership that participates in the program.

Challenges Related to Participation in PQRI

The medical society representatives noted that their members found the PQRI reporting process to be cumbersome, time-consuming, and difficult to understand. A key complaint noted by representatives from medical societies and practices was that CMS frequently did not accept provider reports as valid. This is consistent with CMS data that shows that, of the 109,349 professionals and practices that submitted measures as part of PQRI in 2007, only 52% satisfactorily reported and were eligible to receive the incentive payment.¹

The lack of feedback from CMS on the reporting process was also a key issue of concern for respondents. In particular, medical practice representatives wanted additional information about which claims were unsuccessfully reported to avoid making the same mistakes in the future. Respondents provided anecdotes about providers who were frustrated when they did not receive an incentive payment because they could not identify their reporting mistakes.

¹"Physician Quality Reporting Initiative: 2007 Reporting Experience," Centers for Medicare and Medicaid Services, December 3, 2008: 10. <<http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportExperience.pdf>>

Respondents also expressed a desire for more feedback on performance, such as summary measures about how the medical practice’s performance compared to standards, or

“Feedback. Doctors would appreciate feedback. Did I do it right? Did I do it wrong? How did I compare to my fellow physicians? In a lot of these quality programs, feedback to physicians is actually valued more than the actual money.”

– Medical practice representative

other practices, on the quality measures themselves. One respondent noted that the costs associated with participation in a rural jurisdiction are substantial, and thus adequate feedback is especially important. Another

respondent noted that rural physicians may be less likely to participate in PQRI in the future if they do not receive adequate feedback.

Factors that Affect Rural Physicians’ Participation in PQRI

Practice size and, in conjunction, the extent of the practice’s infrastructure and staff resources were cited by several medical societies as the most important factors that affect a physician’s participation in PQRI. Respondents thought that larger practices were better equipped to participate in P4R programs like PQRI because they have more staff resources and better infrastructure. Additionally, physicians with

“It is just overwhelming for smaller offices. With a one man practice, it’s almost impossible to participate in PQRI.”

– Medical practice representative

electronic medical records (EMRs), patient registries, and standardized data collection systems were thought to have lower marginal costs for collecting

and reporting PQRI data. In contrast, small practices or solo practitioners were thought to be at a disadvantage with respect to participating in PQRI because they lack these resources and infrastructure. Respondents were concerned that solo practitioners and small group practices may be more ambivalent about investing in these systems and making fundamental changes to their operations without knowing whether they will receive an incentive payment. Additionally, some thought that smaller practices – and rural practices in particular – might have difficulty affording the staff time necessary to participate in PQRI. In as much as rural practices are likely to be smaller with fewer resources and less likely to have an EMR, they may face greater challenges when participating in PQRI as compared to their non-rural counterparts.

Respondents also noted that case mix and patient volume were factors that determined whether a physician participates

in PQRI. Many rural physician offices have lower patient volume than their urban counterparts. The fixed cost of setting up reporting systems within the office may be spread over a smaller number of patient visits in a low-volume office. A medical society representative expressed this concern, noting that a rural state does not have the volume of patients to participate in PQRI. Multiple medical society representatives said that Medicare patient volume must be high for physicians to invest the time into reporting because the 1.5 percent incentive needs to be applied to a large payment base to result in a significant amount of money.

On the other hand, some believed that the incentive payment would be sufficient to encourage very rural practices with high Medicare volume to participate in PQRI because of the opportunity for additional revenue. Overall, however, respondents did not believe that the 1.5 percent was a sufficient incentive to encourage broad participation.

Practice size, infrastructure, resources, practice case mix, and volume were identified as the factors that affect whether a physician participates in PQRI. Respondents also mentioned that the physician’s experience participating in other quality reporting or P4P initiatives may influence their decision to participate. Some respondents also noted that they participated in PQRI because of concerns that the program would soon become compulsory.

“[Rural practices] are stuck; they can’t get enough revenue, so they need any measure that would increase their revenue.”

– Medical practice representative

Recommendations to Improve Participation in PQRI

A number of salient recommendations to improve participation in PQRI emerged from the key informant interviews. With regard to reporting, respondents expressed that physicians want greater access to a CMS representative to voice their questions or concerns. Rural primary care physicians that do not receive an incentive payment are likely to discontinue their participation in PQRI without adequate feedback as to why payment was denied. Respondents also recommended a simplification of the reporting process; one respondent suggested that physicians should receive the PQRI reporting instructions in a textbook format with examples. Another medical society representative noted that members would like to know more about why certain measures were selected for inclusion in PQRI, and how the measures were derived. Disseminating information to providers through state medical societies was cited as one way to educate participating professionals about PQRI. Finally, some thought that the implementation of an appeals mechanism could remove a key barrier from participation in cases where reports are denied.

Conclusions and Implications

The purpose of this research was to explore the design and implementation of Medicare's PQRI program in order to assess whether there are any unique opportunities or challenges related to participating that would be systematically different for rural versus urban primary care physicians. Based on findings from our qualitative analysis, we highlight the following conclusions:

- 1. Rural practices may be at a disadvantage with respect to participating in PQRI – not necessarily because of their geographic location, but because they tend to be smaller practices that have fewer resources and a less developed quality measurement infrastructure.** Physicians' practice size, resources, infrastructure, and case mix were identified as factors that could present challenges related to participation. In as much as practice rurality is associated with these factors, rural practices – which tend to be smaller, and have fewer resources and a less developed quality measurement infrastructure – may face greater challenges when participating in PQRI than their non-rural counterparts.
- 2. The 1.5% incentive payment was widely considered insufficient to incentivize primary care physicians to participate in PQRI if they did not have staff and systems to support quality reporting.** Findings suggest that the incentive payment is benefiting practices that are already well-resourced, and potentially need it the least. Practices that have staff dedicated to quality improvement and systems to support quality reporting can participate in PQRI with minimal burden. Conversely, practices that do not have these resources may not participate in PQRI because the costs exceed the value of the incentive payment. To the extent that the American Recovery and Reinvestment Act of 2009 encourages practices to adopt EMRs and other forms of health information technology, this could be less of a problem in the future.
- 3. Rural practices that did not receive the incentive payment and/or did not receive adequate feedback may be less likely to participate in PQRI in the future.** Medical society representatives noted that members did not believe they had received adequate feedback about their participation in PQRI. Given that it is likely a greater burden for some rural physicians to participate in PQRI than their urban counterparts, rural physicians may be less likely to participate in PQRI in the future

if they do not receive adequate feedback. For example, a respondent from a rural medical practice that did not receive a bonus payment – and did not feel that adequate feedback was provided – does not intend to participate in PQRI in the future.

- 4. State medical societies are engaging with their members about PQRI on a limited basis, but could potentially serve as a useful mechanism to disseminate educational information about the initiative.** The study also reveals that medical societies are engaging with their members about PQRI, albeit on a limited basis. Medical societies were identified as an important resource for professionals participating in PQRI, and may be able to disseminate additional resources to their members about PQRI and other P4P and P4R initiatives.
- 5. Further research should investigate the results of the PQRI program for rural primary care physicians, specifically.** The literature review did not identify any research that has quantified rural providers' participation in PQRI. Quantitative analyses of PQRI data over the program's history should explore whether there are statistically significant rural-urban differences in primary care physicians' participation in PQRI, reporting rates, types of measures reported, and incentive amount received. Findings from a more detailed analysis of rural primary care physicians' experiences in PQRI could inform the design and implementation of future CMS P4P and P4R programs, and potentially help to mitigate unintended program consequences for rural providers.

After this study was conducted, the Patient Protection and Affordable Care Act of 2010 made several important changes to PQRI. The legislation extends the program from 2010 until 2014, and includes a punitive component for non-compliant providers. The legislation also mandates the development of a feedback process for providers as well as the coordination of PQRI and the electronic health record (EHR) incentive program established by the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act provides incentive payments to providers who demonstrate meaningful use of EHRs. Finally, in 2014, physicians who do not submit measures to PQRI will have their Medicare payments reduced. Further research is necessary to assess rural physicians' experiences in light of these changes.

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