

Implementation and Impact of Medicare's Voluntary Ambulatory Care Quality Reporting Program*

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Between 2008 and 2014, practices that voluntarily participated in Medicare's Physician Quality Reporting System (PQRS) received financial bonuses for reporting quality performance, along with reports comparing their performance to that of other practices. This snapshot summarizes two studies—one that looked at the decision to participate in PQRS and the implementation process in participating practices, and a second evaluating the impact of PQRS on inappropriate utilization and costs.

Background

Participating practices received financial bonuses that ranged from 0.5 percent to 2.0 percent of Part B allowed charges for reporting performance on at least three quality measures approved by the Centers for Medicare & Medicaid Services (CMS). They also received reports from CMS comparing their performance to that of other reporting practices. In addition, participants knew early on that, beginning in 2015, CMS planned to replace the bonuses with financial penalties for nonparticipation and to incorporate PQRS into the Part B payment system.

Study Methodology

To understand the decision to participate in PQRS and its implementation, researchers conducted focus-group interviews in 2011 with 76 medical group practice administrators. In a separate study, researchers used a multivariate differences-in-differences (DID) model to compare performance on vetted, claims-computable measures of inappropriate utilization and Medicare costs in participating practices to a matched group of nonparticipants.

The three measures of inappropriate utilization included:

- Ambulatory care-sensitive admissions,
- Nonemergent emergency department visits, and
- Potentially preventable readmissions within 15 days of the initial hospitalization.

To compare costs, researchers looked at average annual risk-adjusted, per-beneficiary Medicare expenditures, expressed as a ratio of actual to expected expenditures. The DID model was chosen to account for the fact that participants and nonparticipants likely varied in their pre-PQRS performance on these metrics and potentially on other important characteristics as well. The model focuses on changes in the dependent variables before and after PQRS, thus removing the effect of pre-PQRS differences.

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Takeaway Points

The studies generated the following lessons for those interested in developing effective voluntary quality reporting systems:

- **Actively engage and support practice administrators:** Nonphysician administrators in medical group practices have a larger role than is commonly understood in shaping the adoption and use of quality reporting initiatives. Therefore, they are well positioned to promote appropriate use of resources.
- **Consider tradeoffs between bonuses and penalties:** While bonuses may be necessary early on to gain acceptance of a voluntary reporting program, a timely transition to penalties may be needed to encourage broad levels of participation.
- **Provide actionable, easy-to-use data and tools:** Performance reports and other tools should provide actionable data that are easy to understand and use, including comparisons to similar practices and the ability to drill down to the level of the individual doctor.
- **Support improvement efforts targeted at vulnerable subpopulations:** Not surprisingly, voluntary reporting initiatives can have greater impact on subgroups of providers and/or patients where improvement is most needed. Program sponsors should make special efforts to provide actionable feedback reports and other easy-to-use tools that support improvement efforts targeted at these subpopulations.



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Principal Findings

- **Practice managers played an important role in deciding whether to participate:** In some cases practice managers played an even greater role than the physicians. Most managers considered the benefits and costs of participation, which influenced how they presented the issue to physicians.
- **Larger practices were more likely to participate:** Those most likely to participate had substantial infrastructure, including advanced electronic health record systems.
- **Penalties might be a bigger draw than bonuses:** The managers of practices that decided not to participate suggested that starting with financial penalties might have created more motivation than bonuses of similar magnitude.
- **No association existed between participation and targeted measures:** With few exceptions, participation in PQRS was not associated with significant changes in inappropriate utilization or risk-adjusted costs.
- **PQRS seemed to have a desirable impact on subpopulations prone to overuse:** These subpopulations include male beneficiaries; older beneficiaries; beneficiaries treated in large medical practices and in rural practices; beneficiaries treated by nonphysicians; and beneficiaries with diabetes, heart conditions, and eye problems.
- **PQRS was easy to implement, but administrators judged CMS reports to be of limited value:** Virtually all administrators in participating practices found PQRS easy to implement. However, they reported that the complexity of the performance reports limited their usefulness as a quality improvement tool.

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*Summarized Publications

Robert Coulam, John Kralewski, Bryan Dowd, David Gans. The role of medical group practice administrators in the adoption and implementation of Medicare's physician quality reporting system. *Health Care Management Review* 2015 Mar 2. [published online ahead of print].

Bryan E. Dowd, Tami Swenson, Shriram Parashuram, Robert Coulam, Robert Kane. PQRS participation, inappropriate utilization of health care services, and Medicare expenditures. *Medical Care Research and Review* 2015 Aug 30 [published online ahead of print].

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