

# Current Perspective

## The “Q” Word

Physicians have every reason to be skeptical about the concepts of “measuring quality” or “testing quality.” Washington, D.C., is home to a panoply of organizations with a “Q for quality” in their name. Some of these advance the quality agenda; others have had nominal impacts at best.

I’m occasionally asked, “Why does the Academy abet the quality measurement process?” The answer is pretty straightforward. First, it’s our collective professional mission to continuously improve the quality of the care we all deliver. And that requires the ability to measure the impact of our actions. Second, the quality train has already left the station. We can either take a leadership position ourselves or relinquish the process completely to CMS and commercial payers. Should that occur, we probably will hate the results but will have little leverage to alter them.

The CMS Physician Quality Reporting System (PQRS) has seemed historically to have less to do with quality than with payment for checking the box. The internal medicine community rose up against the American Board of Internal Medicine and its Maintenance of Certification program in part because the “quality” being tested was not felt to be clinically relevant.

Medicare Advantage and commercial payers have wrapped cost-driven network narrowing and decertification in the “quality flag” without transparency or effective risk adjustment. And, finally, we’re told that

patient-reported outcomes (PROs) will become part of the quality assessment equation. It’s no wonder that “health care quality” has a bad rap.

CMS has recently upped the ante. Avoiding a 2 percent PQRS penalty in 2017 depends on meeting a substantively expanded number of measures in 2015. As we transition into the Value-Based Modifier (VBM) system, the penalties grow rapidly to 10 percent or more in two years. For a host of reasons, if you are not part of an integrated multispecialty group or using certain registries (including the Academy’s IRIS Registry), your chances of penalty avoidance are, frankly, very low. The same trend is occurring in the private payer world. Both Aetna and Blue Cross/Blue Shield have announced their intent to inject a quality component into the vast majority of their fee-for-service payments within two years.

None of us entered medicine to be “average,” let alone below average. If we have confidence that the measurements are accurate and actually matter, we will have less concern. If we have a chance to remediate poor performance before being penalized for it, we will be even more comfortable.

There is reason for hope. Thanks to the IRIS Registry, ophthalmology is developing clinically relevant measures of good quality care, focused more on outcomes than process. Moreover, we have the chance to use these measures to avoid penalties. Due to the large data set, we have the potential for

meaningful risk adjustment, which will minimize the adverse impact of complex cases on quality scores.

Finally, PROs are a part of our future. While some question whether patients can judge outcomes of care, they and their employers *are* the purchasers of care, and their judgments should matter. Our objective should be to develop fair and clinically meaningful assessment processes.

As physicians, we would prefer to be judged by the quality of our clinical care. And it is happening with or without us. Because we are the ones who best understand the nuances of the care we provide, our collective mission should be to exert maximal influence to make sure those judgments are fair and evidence-based.



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