The Emerging Quality Measures Revolution

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M.D. News Southeast Michigan (Republished in the Foster Swift Health Care Law Report)
February 2008

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PRACTICE AREAS
Health Care

Too long neglected, quality measures are emerging as the centerpiece of healthcare evaluation, performance and payment for services in the American healthcare system.

Congress, Centers for Medicare and Medicaid services ("CMS") and the Office of the Inspector General have developed and are providing new mantras for quality.

Medicare is moving from its "passive buyer" position to becoming an "active purchaser" of hospital and medical services. "Pay for performance" is the new battle cry and this transformation is being heralded as well by private third party payors and managed care organizations.

Federal programs for improvement in hospital/physician quality of care, such as the Hospital Quality Initiative ("HQI") and the Physician Quality Reporting Initiative ("PQRI") are well beyond initiation and are being reviewed along with other federal programs to provide data on provider performance, evaluation of payment, testing of error rates and error measurement. Of questionable character is the Recovery Audit Contractor program ("RAC") whose contractors receive a percentage of monies they recover from providers. This kind of payment reward based on percentage can lead to contractor abuse of providers and will have to be very carefully monitored.

Providers are being moved to a system not only where their service payments will be more intensely studied, but where pre- and post-payment auditing, licensure, certification, and third party participation issues, for institutional and non-institutional entities, may be dramatically altered.

Value Based Purchasing ("VBP") or provider performance will be more carefully measured and will bring more sophisticate d standards of performance and open areas of provider activity long left dormant.

New bonus initiatives and a potential range of sanctions are now likely to open and endeavor to modify provider behavior.

Long drifting toward same service-same fee, the fee for service payment system may now bring a system of variant payments for the same or similar services depending upon the quality and performance of the rendered service.

Origination theory of measures to evaluate quality of care is not new. Its foremost exponent in the last decades of the twentieth century was Professor Avidas Donnabedian, at the University of Michigan, who formulated quality measures to be denominated as structure, process and outcome measures. Dr. Donnabedian's writings are extensive and are profitably read to gain understanding of the background of measures which have led to the more sophisticated programs now being implemented by CMS and others for data collection and evaluation.

Quality measures themselves will require substantial provider input in their further development and evaluation. This input has already been provided for by federal action.

The impact on providers will no doubt be profound over time. But the impact is likely to be transformative. Wherever our healthcare system is going in terms of service delivery and payment; single payer, multiple payer, or the like, quality of care mandated recently and originally by the federal government is likely to effect the type and depth of care that is given to patients. Providers who look at these trends should be rewarded for their efforts with the advantages of being forearmed in a much changed system.