



Seeking Value in Medicare: Performance Measurement for Clinical Professionals

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OVERVIEW — The Medicare program, despite its reputation of being a bill payer with little regard to the worth of the services it buys, has begun to put in place a range of programs aimed at assessing quality and value, with more to come. Attention to resource use and cost is nascent. The issues are complex, and it is no surprise that there is a level of contention between providers and regulators, even though both profess commitment to improved quality. This paper summarizes the quality and value programs that apply to physicians and other clinical professionals, as well as programs designed to encourage the adoption of technology to support quality improvement. Participation in all is voluntary. However, a decision not to participate increasingly carries a financial penalty, as Congress (and, by extension, the U.S. Department of Health and Human Services, or HHS) tries to encourage behavior it cannot force.

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The U.S. Department of Health and Human Services (HHS) has been implementing programs such as the Physician Quality Reporting System, the Physician Feedback/Value-Based Payment Modifier Program, Physician Compare, the Electronic Prescribing (eRx) Incentive Program, the EHR Incentive Program, and others in its efforts to improve quality of care and curb costs. Following is a summary of each of these programs, along with brief discussion on the issues raised for care providers, beneficiaries, and policymakers.

PHYSICIAN QUALITY REPORTING SYSTEM

The Tax Relief and Health Care Act of 2006 required the establishment of a quality reporting system for eligible health care professionals, incorporating an incentive payment for those who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries. Though the Centers for Medicare & Medicaid Services (CMS) named it the *Physician Quality Reporting Initiative (PQRI)*, eligible professionals also include physician assistants, advanced practice registered nurses, and others such as speech and physical therapists.¹

Seventy-four quality measures were made available for 2007, when reporting occurred only via submitted claims. Those who met reporting criteria were eligible to be paid a lump-sum bonus equal to 1.5 percent of their estimated allowable charges under Medicare Part B. Starting in 2008, there were 119 measures from which physicians could select a minimum of three to report, primarily reflecting their specialty. Each measure carries requirements as to the minimum percentage and/or number of the physician's patients that must be included in the reporting.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 extended the incentive payments to 2008 and 2009. It authorized CMS to establish reporting criteria for measures groups and for the submission of PQRI quality data via registries. A "measures group" combines several individual measures under one disease heading. For example,

the Chronic Obstructive Pulmonary Disease (COPD) measures group incorporates measures such as COPD spirometry evaluation, bronchodilator therapy, and influenza immunization. A “registry” is an information system designed to support care management, often of a particular disease such as diabetes or cancer.

Congress extended PQRI indefinitely under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), raising the bonus for reporting to 2.0 percent of allowed charges for covered professional services in 2009 and 2010. Fifty-two additional measures were added, including 18 measures designated for reporting via registries. MIPPA further required the Secretary of HHS to develop a plan to transition from the fee-for-service system to a value-based purchasing (VBP) system for professional services.

By 2010, there were 179 individual measures and 13 measures groups. CMS allowed physician groups of at least 200 eligible professionals filing under the same tax identification number to report as groups rather than as individuals. Under the Patient Protection and Affordable Care Act of 2010 (ACA), there was a name change to the Physician Quality Reporting *System* (PQRS). Eligible professionals were given the opportunity to earn an additional 0.5 percent incentive payment by successfully participating in an authorized maintenance of certification (MOC) program more frequently than necessary to maintain board certification.²

Incentive payments will be awarded through 2014, though payment percentages have fallen to 0.5 percent for reporting alone or 1.0 percent with the addition of MOC. Beginning in 2015, the tables turn. Physicians who do not report quality data for 2013 become subject to a penalty of 1.5 percent in 2015 and 2.0 percent in years thereafter. (CMS, rather carefully, calls this a “payment adjustment,” but the adjustment is negative.)

For 2013, eligible professionals may choose to report information on PQRS quality measures or measure groups to:

- CMS as part of their Part B claims,
- a qualified registry,
- CMS via a qualified electronic health record product, or
- a qualified PQRS data submission vendor.

Groups of 25 professionals or more may also choose the Group Practice Reporting Option (GPRO), a web-based interface discussed further below.

In 2011, the most recent year for which information is available, a little over 1.1 million professionals were eligible to participate in PQRS; of these, 320,422 or 29 percent, actually did participate, and 266,521 received incentive payments.³ The 2011 figures represented an increase over the corresponding 2010 figures in which 269,076 professionals participated and 194,278 were paid a bonus.

PHYSICIAN FEEDBACK/VALUE-BASED PAYMENT MODIFIER PROGRAM

A program to provide feedback to physicians on the quality data they submit was introduced in MIPPA and expanded under the ACA. The ACA mandated that, by 2015, CMS develop and implement a value-based modifier under the Medicare Physician Fee Schedule (MPFS). The modifier (hereafter referred to as the VBM) is intended to provide for “differential payment under the [MPFS] based upon the quality of care furnished compared to cost during a performance period.”⁴ The VBM is based on data submitted to the PQRS, thus adding a performance dimension to the pay-for-reporting under that system.

Physicians in groups of 100 or more, filing under a single taxpayer identification number, will be subject to the VBM in 2015 on the basis of their performance in 2013. The VBM program will be expanded to all physicians participating in PQRS by 2017.

Looking ahead to 2015, physician groups with more than 100 members have four choices:

- Register for PQRS and submit data for at least one measure via the web-based GPRO. The 2015 VBM will be set at 0.0 percent.
- Register for PQRS and elect the administrative claims option as a group. This means that CMS will analyze the group’s Medicare claims to assess performance on 17 predetermined measures. Again, the 2015 VBM is 0.0 percent.
- Elect to have their modifier calculated using what is called quality-tiering methodology. In this case, CMS does a calculation on the basis of the quality measures reported through PQRS to produce

a quality composite score and a cost composite score. A group's VBM may be positive, negative, or neutral. Groups found to be high-quality and low-cost may receive as much as a 2.0 percent incentive payment, while those deemed low-quality and high-cost will have their payments adjusted downward by 1.0 percent (see Table 1).

- Opt not to submit data via the GPRO or to elect the administrative claims option; this failure to submit results in a -1.0 percent payment adjustment in 2015. It should be noted that this negative adjustment would be in addition to the -1.5 percent adjustment for not participating in PQRS.

The GPRO measures largely involve primary and preventive care, whereas registries tend to be more targeted to specialties. It is not clear that the entire universe of medical care being delivered is encompassed in the quality measures currently available.

There are five cost measures: total per capita cost of the group's Medicare FFS patients and per capita costs for beneficiaries with four specific chronic conditions: COPD, heart failure, chronic artery disease, and diabetes. CMS risk-adjusts the group's Medicare patient population based on characteristics such as age, gender, Medicaid eligibility, and medical history.⁵

For 2015 and 2016, CMS will refrain from applying the VBM to physician groups participating in the Medicare Shared Savings Program, the Pioneer Accountable Care Organization (ACO) groups, or the Comprehensive Primary Care Initiative.

As part of the PQRS/VBM programs, CMS will provide feedback to physician groups. Quality and Resource Use Reports (QRURs) are being rolled out gradually. In 2012, reports were given to 54 large medical groups that had submitted data via the GPRO. In 2013, CMS disseminated reports to 3,876 medical groups with 25 or more eligible professionals.⁶

PHYSICIAN COMPARE

The development of a Physician Compare web site, analogous to the older Hospital Compare site, was mandated by the ACA. It was built on the Healthcare Provider Directory (a listing of physicians

TABLE 1
Value-Based Modifier Under
Quality Tiering

QUALITY	COST		
	Low	Average	High
High	+2.0	+1.0	0.0
Average	+1.0	0.0	-0.5
Low	0.0	-0.5	-1.0

participating in Medicare) that already existed on medicare.gov. Its eventual mission is two-fold:

- to provide information for consumers to encourage informed healthcare decisions; and
- to create explicit incentives for physicians to maximize performance.

Information on the site as of August 2013, while useful to know, does not seem to markedly advance either aspiration. The information seeker can sort on the basis of specialty, distance to practice site, physician name, and whether the physician accepts Medicare assignment (that is, will not bill the patient any amount beyond Medicare's deductible and coinsurance). Search is also possible based on medical condition. At the individual physician level, the seeker can find contact information, gender, directions to the practice site, board certifications (if any), and whether the physician speaks languages other than English. Information on the physician's medical school and hospital affiliations are given in most but not all cases. Participation in the PQRS and the electronic prescribing incentive EHR incentive program (see below) is noted.

Plans to post quality and efficiency data on the site, as ACA requires, are in progress. CMS has indicated its intention to post an initial set of measures for group practices in 2014, using data collected no earlier than 2012. These data will be drawn from PQRS GPRO and ACO filings. Patient experience data, such as those collected through the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) survey, are expected to be added as soon as feasible for ACOs and medical groups with more than 100 professionals.⁷

ELECTRONIC PRESCRIBING (eRX) INCENTIVE PROGRAM

Electronic prescribing was enabled in 2001 by the creation of information networks then known as Surescripts and RxHub (since merged under the Surescripts name) by major players in the pharmacy industry. However, providers were slow to adopt the technology. In 2005 CMS established e-prescribing standards. By 2007, state pharmacy boards had accepted the legality of e-prescribing.⁸ A quality measure related to e-prescribing was included in PQRI in 2008.

MIPPA legislation replaced the measure with an independent incentive program for 2009.

Under this program, eligible professionals submit data on the e-prescribing quality measure, describing their use of a qualified eRx system during visits with a minimum of 25 Medicare Part B fee-for-service beneficiaries.⁹ The physician attests to having generated and transmitted at least one prescription electronically during these encounters, known as “eligible instances.” Data is submitted via claims or through a qualified registry or EHR vendor.

Eligible professionals who successfully e-prescribe for covered services are eligible for an incentive payment. As established in law, for 2009 and 2010, the incentive amount was 2 percent of a provider’s total estimated allowed charges for covered professional services during the reporting period (one calendar year). The incentive amount was reduced to 1 percent in 2011 and 2012 and further reduced to 0.5 percent in 2013. Beginning in 2014, those who are not successful e-prescribers will be subject to a downward payment adjustment of 2 percent.

The universe of eligible eRx professionals is smaller than for PQRS because, in order to qualify, a physician’s system must be able to:

- generate a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBMs) if available;
- select medications, print prescriptions, electronically transmit prescriptions, and conduct all alerts;
- provide information related to lower cost and therapeutically appropriate alternatives (if any); and
- provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient’s drug plan (if available).¹⁰

Eligible professionals who were successful electronic prescribers received an average bonus payment of just over \$3,000 from the e-prescribing Incentive Program in 2009; \$3,836 in 2010; and \$1,912 in 2011. The lesser amount in 2011 reflects the decrease in the incentive percentage from 2 to 1 percent. CMS made payments to 174,189 professionals in 2011.¹¹

EHR INCENTIVE PROGRAM

The EHR incentive program provides incentive payments for certain health care providers to use EHR technology in ways that improve patient care.¹² In order to receive payment, providers must show that they have gone beyond acquisition of an EHR system and are in fact “meaningfully” using it. The standards for so demonstrating, developed under the authority of the Office of the National Coordinator for Health Information Technology (ONC), give the program its more common appellation of “meaningful use.” ONC has also established technical and functional standards that EHRs must meet in order to qualify for the incentive program.

The Medicare EHR incentive program was authorized under HITECH (the Health Information Technology for Economic and Clinical Health) Act in 2009. Payments began in 2011 and will continue through 2016. Its Medicaid counterpart will continue to make incentive payments through 2021. Eligible professionals can earn up to \$44,000 under the Medicare EHR incentive programs and up to \$63,750 under Medicaid.¹³ (A person eligible for both may choose only one.) As of June 2013, the combined programs for eligible professionals had a cumulative total of 400,960 registrants, of whom 293,861 had received an incentive payment for a total expenditure of approximately \$5.99 billion.¹⁴

There are three stages of meaningful use criteria. Stage 1, which began in 2011, sets the basic functionalities an EHR must offer and requires the physician to engage in data capture and some data sharing. Stage 2 – with the final rule published in September 2012 – increases health information exchange among providers and gives patients secure online access to their health information.¹⁵ Originally scheduled to take effect in 2013, Stage 2 requirements were delayed until 2014. Many providers, as represented by organized medicine groups, would prefer additional delay.¹⁶ Stage 3, in development but not scheduled to debut until 2016, will continue to expand meaningful use objectives to improve health outcomes.¹⁷

Participation in the EHR incentive program is voluntary. However, here too a non-participation penalty kicks in eventually. Beginning in 2015, eligible professionals who fail to demonstrate meaningful use will face payment adjustments, beginning at –1 percent and increasing each year thereafter to a maximum of –5 percent.

OTHER PROGRAMS

As stated earlier, the programs described above are voluntary, but clearly designed to encourage broad participation. Other Medicare programs and demonstrations require application and competition in order to be included, or are a function of physician choice and/or location. For example, a decision to become part of an Accountable Care Organization under the Medicare Shared Savings Program depends on the characteristics and relationships of the physician's local market. Physicians taking part in the Comprehensive Primary Care Initiative had to live in one of the seven locations CMS chose as test sites and then had to be selected through a competitive process as a participating practice.

IMPACT OF PROGRAMS

The programs discussed above have the common goals of improving health care quality and reducing its cost; ideally, they would work together to make physician participation easy and fruitful. In fact, a big complaint on the part of physicians has been insufficient alignment of quality measures. CMS has taken steps in this direction, including contracting with the National Quality Forum to review quality and efficiency measures under CMS consideration with an eye to harmonizing them across federal programs.¹⁸ However, physicians have not yet been presented with a seamless process whereby one reporting mechanism for one set of measures satisfies the requirements of various programs. Perhaps more troubling is their general lack of belief in the utility of the programs. Much of this is expressed anecdotally, but a survey by researchers at Mt. Sinai School of Medicine found that fully half of responding physicians who participated in PQRS believed it had no impact on quality.¹⁹

A tension inherent in these programs is whether quality and efficiency is measured at the group or individual level. Physicians have made the reasonable point that any one of them may not have enough patients with a particular diagnosis to generate reliable data. Many, particularly solo or small-practice physicians, have complained of the administrative burden. There are also issues of attribution if a patient sees multiple physicians in a practice, that is, on whose record does that patient "count"? Consumers tend to want information about individual clinicians and may misinterpret quality information

reported at the group level when they have navigated to an individual physician's page in Physician Compare.

It is difficult at this stage to determine patient awareness of the consumer-focused Physician Compare program, still less value-based purchasing or meaningful use. But it is fair to say that consumers no less than clinicians are involved in significant culture change, contemplating a world where decisions are to be shared by doctor and patient, more doesn't necessarily mean better, and cost does matter.

ENDNOTES

1. A full list is available at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_List-of-EligibleProfessionals_022813.pdf.
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4. CMS, "Summary of 2015 Physician Value-Based Payment Modifier Policies," www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/CY2015ValueModifierPolicies.pdf.
5. Joel V. Brill, "QRUR reports will be key in deciding Medicare pay," *GI & Hepatology News*, April 25, 2013, www.gihepnews.com/news/practice-management/single-article/qrur-reports-will-be-key-in-deciding-medicare-pay/0c498028c5e82be47f117de925d43178.html.
6. CMS, "Medicare Physician Feedback Program/Value-Based Payment Modifier: Background," updated April 17, 2013, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Background.html; and CMS, "Medicare Physician Feedback Program/Value-Based Payment Modifier: 2012 QRUR," updated September 24, 2013, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2012-QRUR.html.
7. CMS, "Physician Compare Overview," updated June 26, 2013, www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/Physician-Compare-Overview.html.
8. E-prescribing of controlled substances is subject to U.S. Drug Enforcement Administration (DEA) regulation and oversight; a major policy revision permitting e-prescribing took effect in 2010. For more information, see DEA, Office of Diversion Control, "Electronic Prescriptions for Controlled Substances (EPCS)," www.deadiversion.usdoj.gov/ecommm/e_rx/.

9. CMS, "Electronic Prescribing (eRx) Incentive Program," updated July 17, 2013, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/>.
10. CMS, *2011 Reporting Experience Including Trends (2008-2012)*, p. 33.
11. CMS, *2011 Reporting Experience Including Trends (2008-2012)*, p. 38.
12. CMS, "An Introduction to the Medicare EHR Incentive Program for Eligible Professionals," p. 4, www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Beginners_Guide.pdf.
13. CMS, "EHR Incentive Programs: Medicare and Medicaid EHR Incentive Program Basics," updated June 26, 2013, www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html.
14. CMS, Monthly Payment and Registration Summary Report, June 2013, www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/June_PaymentRegistration_Summary.pdf.
15. Full text of the final rule is available at *Federal Register*, 77, no. 1, September 4, 2012, www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf.
16. See, for example, the American Medical Association's June 14, 2013, letter to Secretary Sebelius, available at www.ama-assn.org/resources/doc/washington/icd-10-letter-14june2013.pdf, or the American Academy of Family Physicians' August 7, 2013, letter to CMS's Marilyn Tavenner and National Coordinator of Health Information Technology Farzad Mostashari, www.aafp.org/dam/AAFP/documents/advocacy/health_it/emr/LT-CMS-MU2-080713.pdf.
17. U.S. Department of Health and Human Services, "HHS Announces Next Steps To Promote Use of Electronic Health Records and Health Information Exchange," press release, August 23, 2012, www.hhs.gov/news/press/2012pres/08/20120823b.html.
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