



2011 Reporting Experience

Including Trends (2008-2012)

Physician Quality Reporting System and
Electronic Prescribing (eRx) Incentive program

4/09/2013

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I. EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) implemented two pay-for-reporting programs for eligible professionals.¹ The Physician Quality Reporting System (formerly, Physician Quality Reporting Initiative or PQRI), authorized under Section 101(b) of division B of the Tax Relief and Health Care Act (TRHCA) of 2006 (Public Law 109423; 120 Stat. 2975), entered its fifth year in 2011 and has grown substantially from its inception in 2007. The Electronic Prescribing (eRx) Incentive Program, authorized under Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), was introduced in 2009 as a separate incentive vehicle for eligible professionals. Prior to 2009, the eRx measure was an individual measure within the 2008 Physician Quality Reporting System. These programs encourage eligible professionals to report on clinical quality measures by providing a series of payment incentives and payment adjustments based on a percentage of the total estimated Part B Medicare Physician Fee Schedule (MPFS) allowed charges for covered professional services furnished by the eligible professional during the reporting period. Beginning in calendar year 2012, a payment adjustment is applicable to eligible professionals who are not successful electronic prescribers under the eRx program; a payment adjustment will also be applied under the Physician Quality Reporting System beginning in calendar year 2015.

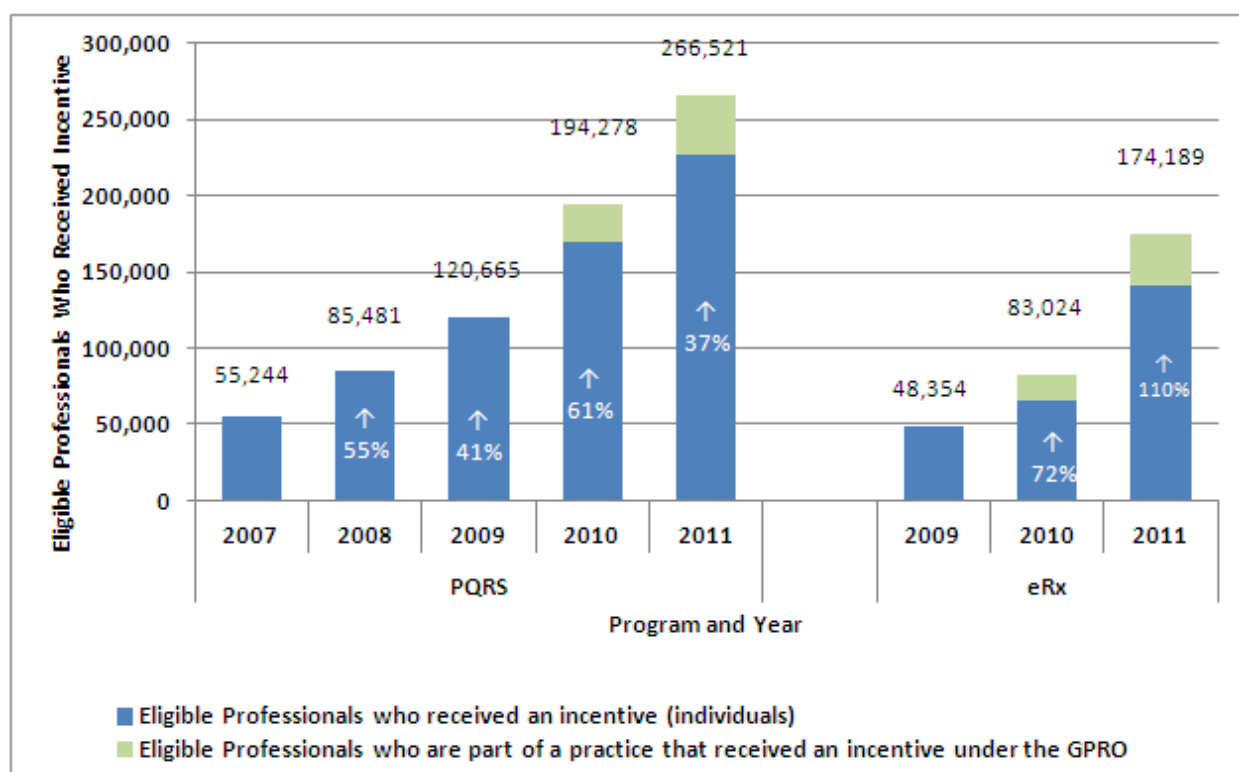
This report summarizes the reporting experience of eligible professionals in these programs in 2011, historical trends, and preliminary results for the 2012 program year. Unless otherwise noted, all tables and figures present 2011 data. Findings reported at the practice level include both eligible professionals participating individually, summarized at the practice level, as well as practices that participated through the group practice reporting option (GPRO). While the GPRO is not an individual participation option, the participation information from the GPRO was sometimes combined with individual participation options to describe the total number of individual eligible professionals, including those who are part of group practices that report under the GPRO.

¹ An eligible professional is a physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, audiologist, physical or occupational therapist, or qualified speech-language pathologist.

Incentive Payments

- The Physician Quality Reporting System and the eRx Incentive Program, combined, paid \$546,782,339 in incentives in 2011.

Figure 1. Number of Eligible Professionals Who Qualified for an Incentive: Physician Quality Reporting System Results (2007 to 2011) and eRx Incentive Program Results (2009 to 2011)



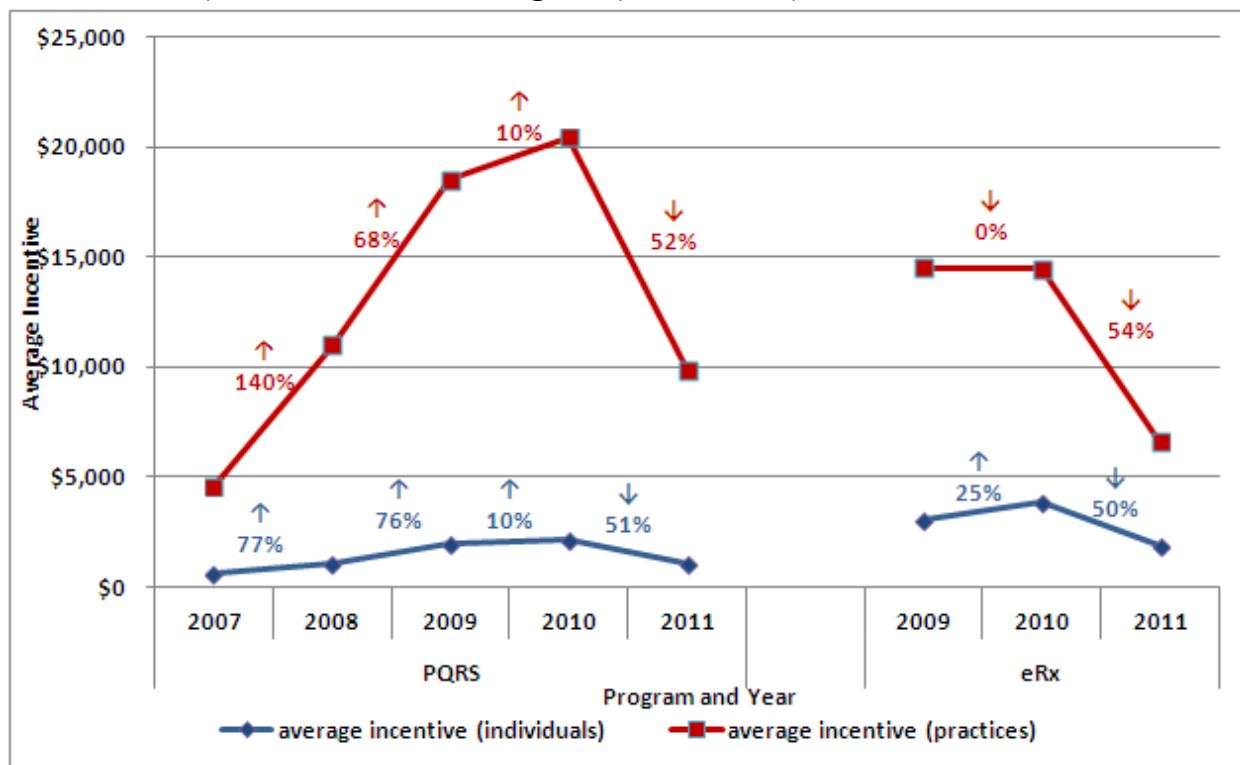
Note for Figure 1: Results included all participation mechanisms and options (i.e., claims, registry, EHR, GPRO I, and GPRO II).

- A total of \$261,733,236 in Physician Quality Reporting System incentive payments was paid by CMS for the 2011 program year, which reflects successful participation of 26,515 practices that included 266,521 eligible professionals.²
 - The number of eligible professionals who qualified for an incentive for the 2011 Physician Quality Reporting System (266,521) increased 37 percent from 2010 (194,278) including eligible professionals who were part of a group practice that was incentive eligible under the GPRO.
 - Group practices that participated under the GPRO included 39,460 eligible professionals; they were paid a total of \$21,302,298.
 - The number of practices that received an incentive for the 2011 program year (26,515) increased 38 percent compared to 2010 (19,232).

² These numbers include eligible professionals who participated individually, summarized at the practice level, as well as eligible professionals who were part of a group practice that participated under the GPRO.

- The average incentive was \$1,059 per individually-participating eligible professional and \$9,863 per practice; the average incentive decreased by about one-half from 2010 following a drop in the incentive payment percentage from two to one percent.
- A total of \$285,049,103 in eRx Incentive Program incentives was paid for the 2011 program year, which encompassed 174,189 eligible professionals (including those who were part of an incentive eligible group practice that participated under the GPRO) and 43,132 practices.
 - Total incentive payments for the 2011 eRx Incentive Program increased five percent compared to 2010 (\$270,895,540), despite a change in the incentive payments equal to one percent (down from two percent) of the estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional or group practice during the applicable reporting period.
 - Practices that were incentive eligible and reported under the GPRO included 33,820 eligible professionals; they were paid a total of \$16,699,366.
 - The number of practices that qualified for an incentive in the 2011 eRx Incentive Program (43,132) increased 130 percent compared to 2010 (18,713).
 - The average eRx incentive payment was \$1,912 per eligible professional and \$6,609 per practice.

Figure 2. Average Incentive Payments for the Physician Quality Reporting System (2007 to 2011) and eRx Incentive Program (2009 to 2011)



Note for Figure 2: Results include incentives for participants under all participation mechanisms and options (i.e., claims, registry, EHR, GPRO I, and GPRO II).

Expansion of Programs and Eligibility

- The 2011 Physician Quality Reporting System and the eRx Incentive Program retained the same reporting options (individual reporting options and group reporting options) as well as mechanisms (claims, registry, and EHR) from the 2010 program—although the GPRO option was extended to smaller practices in 2011.

Table 1. Summary of Reporting Options and Mechanisms for the Physician Quality Reporting System and eRx Incentive Program (2010 to 2012)

Reporting Options and Mechanisms	PQRS 2010	PQRS 2011	PQRS 2012	eRx 2010	eRx 2011	eRx 2012
Individual Participation Option	--	--	--	--	--	--
Claims-based: Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes
Claims-based: Measures Groups	Yes	Yes	Yes	-	-	-
Registry: Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes
Registry: Measures Groups	Yes	Yes	Yes	-	-	-
Electronic Health Record (EHR)	Yes	Yes	Yes	Yes	Yes	Yes
Group Practice Reporting Option (GPRO)¹	--	--	--	--	--	--
GPRO I web-interface	Yes	Yes	-	-	-	-
GPRO I claims	-	-	-	Yes	Yes	-
GPRO I registry	-	-	-	Yes	Yes	-
GPRO I EHR	-	-	-	Yes	Yes	-
GPRO II claims	-	Yes	-	-	Yes	-
GPRO II registry	-	Yes	-	-	Yes	-
GPRO II EHR	-	-	-	-	Yes	-

Notes for Table 1: In 2012, GPRO I and GPRO II will be replaced with Large and Small GPRO. Both Large and Small GPRO will use a web interface to report Physician Quality Reporting System Measures, while the eRx measures will be reported through claims, registry, or EHR. Note that prior to 2011, GPRO reported via a GPRO tool.

- Of the 101 practices approved by CMS to participate in the Physician Quality Reporting System under the GPRO, 92 participated (submitted valid QDCs).
 - Among the practices participating under the GPRO, 54 had at least 200 eligible professionals (GPRO I) and another 38 practices had between two and 199 eligible professionals (GPRO II).
- The number of quality measures from which eligible professionals could choose to participate in the Physician Quality Reporting System continued to increase in the 2011 program (Table 2).

Table 2. Number of Physician Quality Reporting System Measures (2010 to 2012)

	2010	2011	2012
Total Number of measures	179	198	266
Number of measures groups	13	14	22
Number of measures within measures groups	76	78	117
Number of measures reportable via claims	129	131	143
Number of measures reportable via registry	175	186	208
Number of measures reportable via EHR	10	20	51
Number of measures reportable via GPRO (I)	26	26	29
Number of measures reportable via GPRO II	N/A	189	N/A

Note for Table 2: Total number of measures reflects all measures, including all possible reporting mechanisms and options. In 2010, GPRO I was referred to as GPRO; in 2012, GPRO I and GPRO II will be replaced with Large and Small GPRO.

- The measures reportable by the largest number of eligible professionals were mostly preventive measures, which are not specific to a given diagnosis or condition and apply to a broad range of specialties (Tables 3 and 14).

Table 3. Top Five Individual Measures Reportable by the Largest Number of Eligible Professionals for the Physician Quality Reporting System (2011)

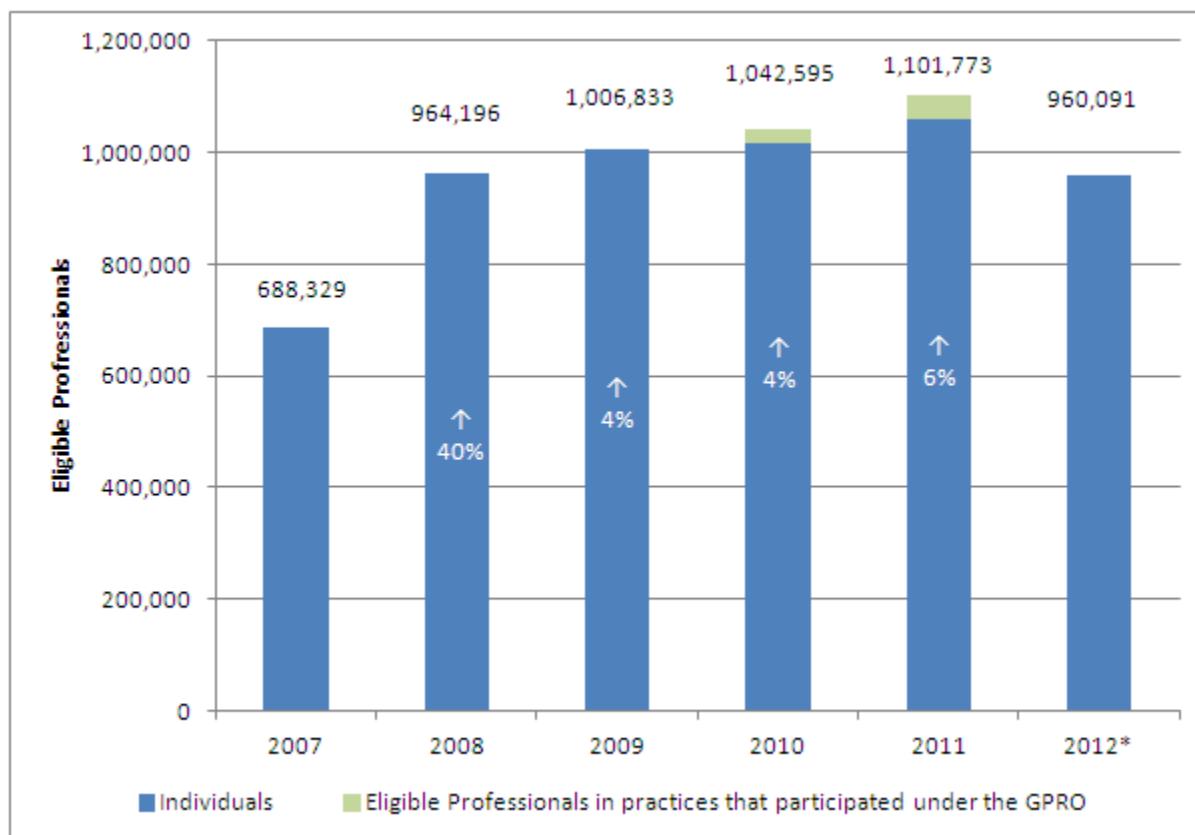
Measure Number	Measure Name	Eligible Professionals
124	HIT - Adoption/Use of EHRs	781,820
128	Universal Weight Screening and Follow-Up	722,617
130	Documentation of Current Medications	710,120
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	682,002
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	675,446

Note for Table 3: Results included the claims, registry, and EHR mechanisms, excluding eligible professionals who were part of a group practice that participated under the GPRO.

- More than one million eligible professionals could have participated in the 2011 Physician Quality Reporting System (Figure 3).
- Eligible professionals who could participate in the Physician Quality Reporting System were concentrated in specialties such as family practice, internal medicine, and emergency medicine. CMS aims to include quality measures that are applicable to all specialties and annually requests suggestions for measures to be included in the Physician Quality Reporting System.
- 748,224 eligible professionals could have participated in the 2011 eRx Incentive Program including those who were part of a group practice that self-nominated to participate under the GPRO; 43 group practices that self-nominated and indicated

their intent to report eRx were able to participate via the GPRO I for the eRx Incentive Program, while 31 practices were able to participate via the GPRO II.

Figure 3. Total Number of Professionals Eligible to Participate in the Physician Quality Reporting System (2008 to 2012*)



Notes for Figure 3: Results include all reporting mechanisms and options. *2012 is preliminary data (six months) and does not include reporting via a Registry, EHR, or under the GPRO.

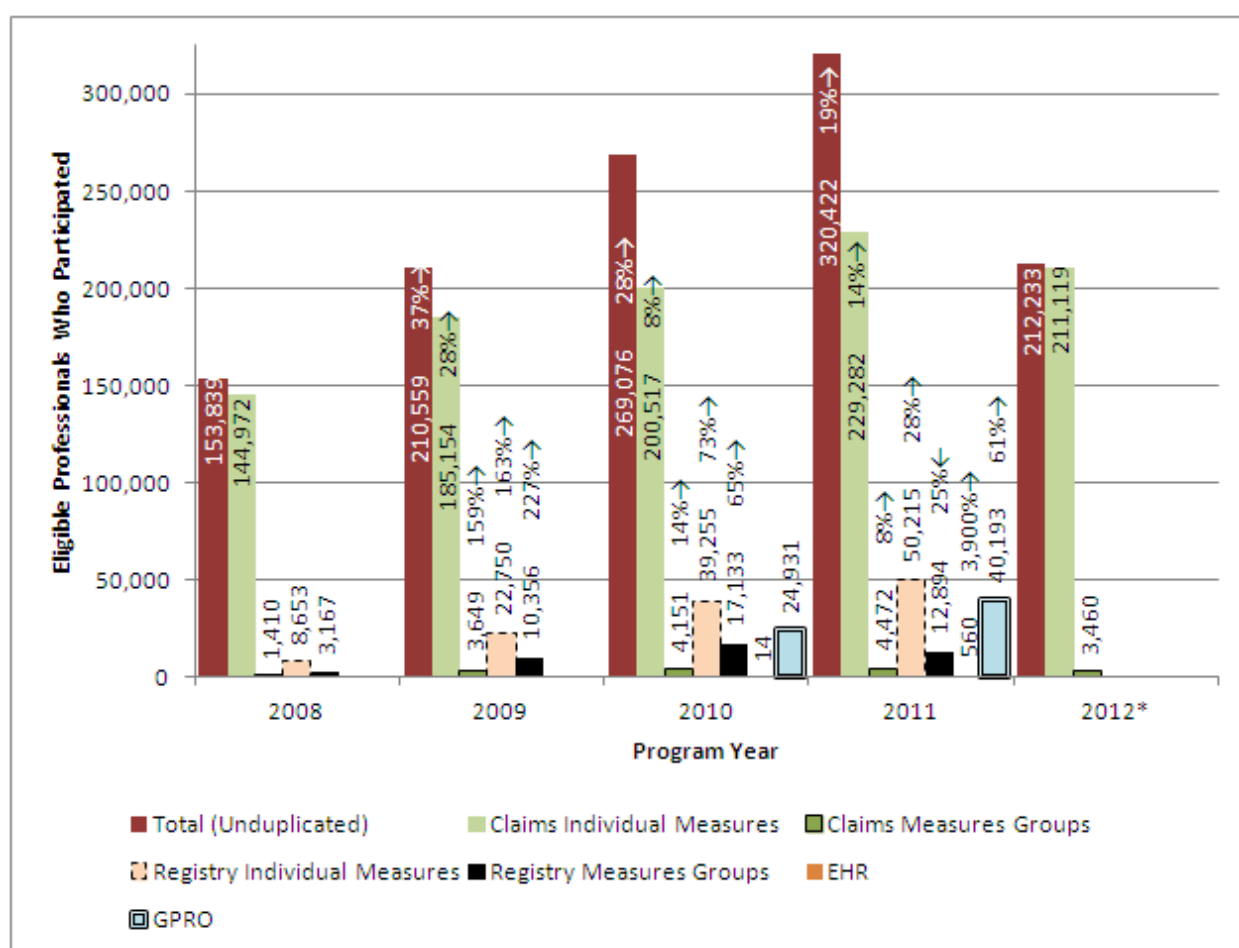
Participation

- Participation increased every year in both the Physician Quality Reporting System and eRx Incentive Program (Figures 4 and 5).
 - Most recently (i.e., 2010 to 2011), the number of eligible professionals who participated increased 19 percent and 116 percent for the Physician Quality Reporting System and eRx Incentive Program, respectively (Figures 4 and 5).
- In 2011, 320,422 eligible professionals (including those encompassed in group practices that reported under the GPRO) participated in the Physician Quality Reporting System through at least one method, a notable increase from the roughly 100,000 who participated in 2007.³

³ Refer to Section III for a description of measure submission approaches.

- The participation rate among all eligible professionals using any method to participate in the Physician Quality Reporting System increased from 15 percent to 29 percent between 2007 and 2011 (including those who were part of a group practice that participated under the GPRO).
 - While the most common participation method in the Physician Quality Reporting System continued to be reporting individual measures through claims, participation in all reporting mechanisms increased each year from 2008 to 2011 except for a small drop in registry-based measures group participants from 2010 to 2011 (Figure 4).

Figure 4. Total Number of Eligible Professionals Participating in the Physician Quality Reporting System, by Reporting Mechanism (2008 to 2012*)



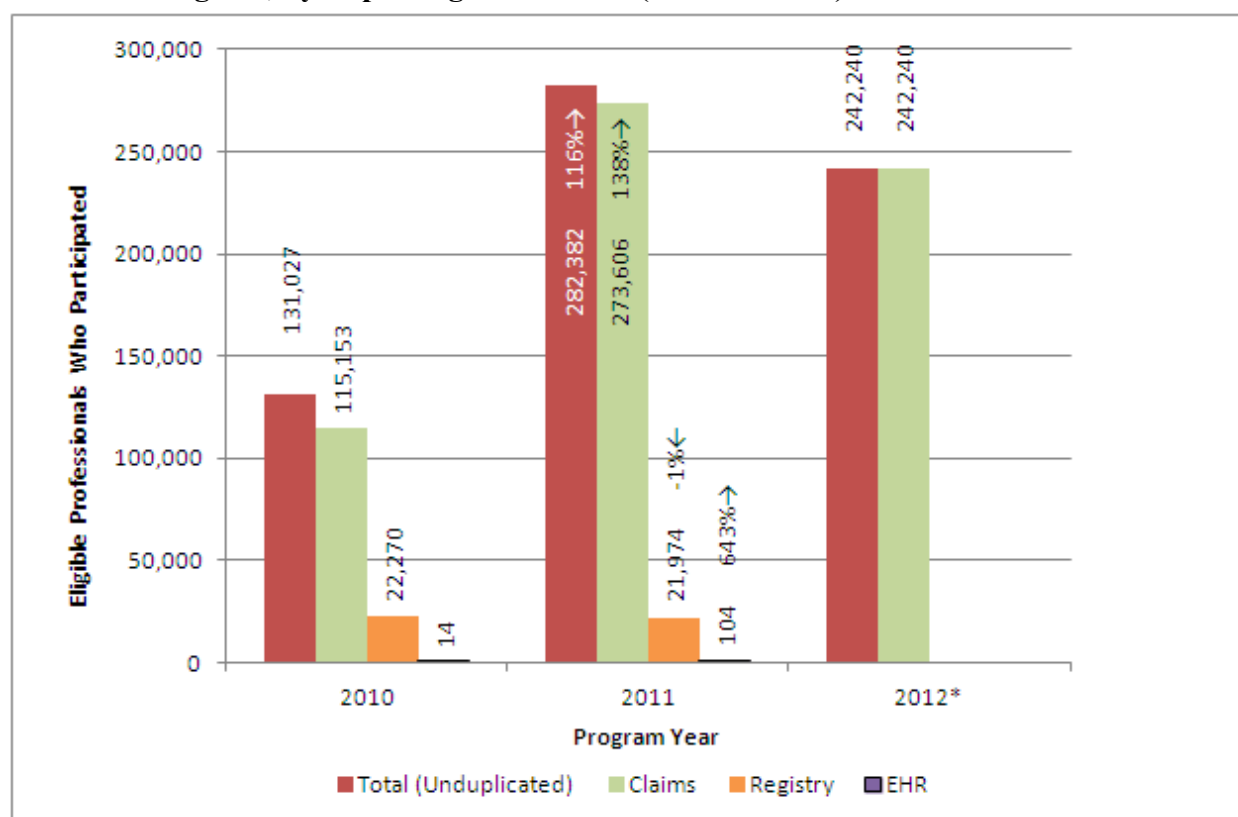
*Note for Figure 4: Results include individually participating eligible professionals as well as eligible professionals in group practices that participated under the GPRO. Some eligible professionals participated in more than one method. *Results for 2012 are preliminary only (six months); data reported via registry, EHR, and under the GPRO are not yet available.*

- In 2011, 560 eligible professionals submitted quality data for the Physician Quality Reporting System through a qualified EHR, while 104 eligible professionals submitted quality data through the eRx Incentive Program EHR mechanism. This is a

substantial increase from 2010 when 14 eligible professionals submitted data through a qualified EHR to the Physician Quality Reporting System and to the eRx Incentive Program.

- Of the 101 practices that self-nominated for the Physician Quality Reporting System GPRO options, 92 participated, encompassing 39,404 eligible professionals under the GPRO I and 789 eligible professionals under the GPRO II.
- In addition, 43 group practices (encompassing 34,943 eligible professionals) participated in the eRx Incentive Program under the GPRO I and 31 practices (encompassing 674 eligible professionals) participated under the GPRO II.

Figure 5. Total Number of Eligible Professionals Participating in the eRx Incentive Program, by Reporting Mechanism (2010 to 2012*)



*Notes for Figure 5: Results include individually participating eligible professionals as well as eligible professionals in group practices that participated under a GPRO. *Results for 2012 are preliminary only (six months); data reported via registry, EHR, and under the GPRO are not yet available.*

- In 2011, 282,382 eligible professionals participated in the eRx Incentive Program with 97 percent participating through claims (Figure 5).
- In 2011, 38 percent of those eligible to participate participated in the eRx Incentive Program, an increase from 16 percent of those eligible in 2010 (includes those participating under the GPRO); the number of participants in the eRx Incentive Program increased by 138 percent from 2010 to 2011.
 - Preliminary data for 2012 eRx Incentive Program show the number of eligible professionals who participated by reporting through claims during the first six

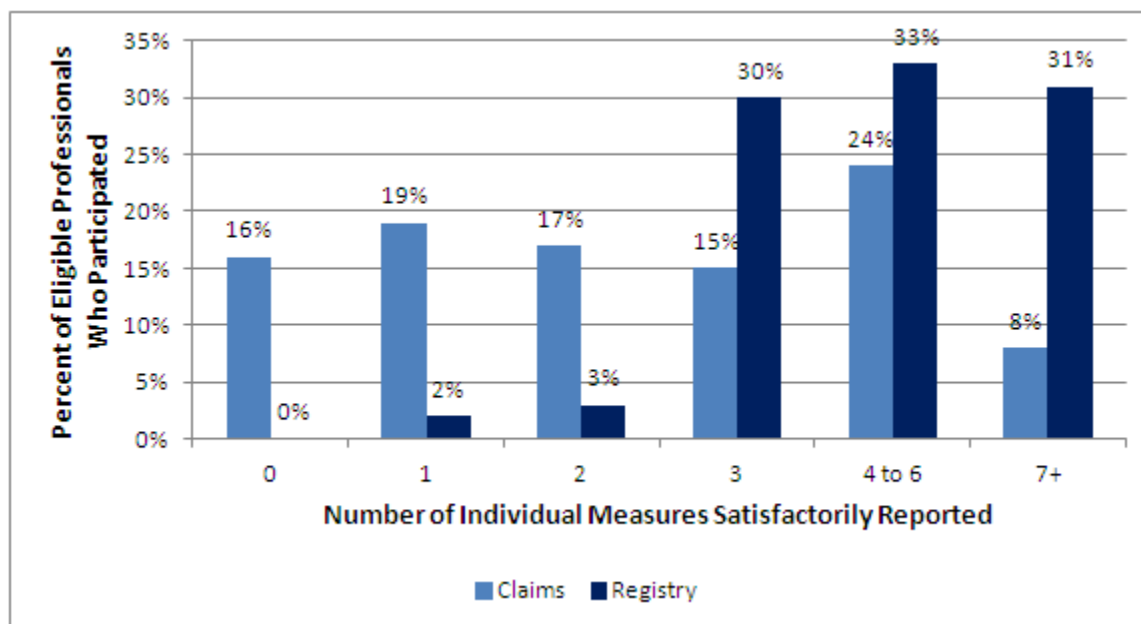
months of 2012 is approximately equal to the total number who participated using any reporting mechanism in the 2011 program.

- Some specialties participated in greater numbers and/or at higher rates in the 2011 programs than others.
 - Emergency physicians, family practitioners, internists and anesthesiologists had the largest numbers of participants in the Physician Quality Reporting System across all individual reporting options. Internists and family practitioners had the largest number of participants using claims-based measures groups and the registry submission mechanism under the Physician Quality Reporting System.
 - Among all specialties, family practitioners and internists had the largest number of participants in the eRx Incentive Program, while cardiologists and rheumatologists had the highest participation rates (64 percent and 62 percent, respectively).
- Some eligible professionals and practices participated in both the Physician Quality Reporting System and the eRx Incentive Program (Table 4).
 - In 2011, 137,443 individual eligible professionals and 22,269 practices participated in both programs.

Satisfactory Reporting and Challenges to Reporting

- In 2011, 84 percent of eligible professionals who participated in the Physician Quality Reporting System satisfactorily reported at least one individual measure through claims, compared with 100 percent of registry participants (Figure 6).
 - That is, 16 percent of those who attempted to participate via claims were unable to submit any measures satisfactorily, compared to zero percent for those using registry.
- The most common claims-based submission error was reporting a measure-specific Quality Data Code (QDC) on a claim that did not also have the required procedure code.
- The most common reporting errors via registry were incorrect reporting rates, invalid measures, and submitting data for TIN/NPI that had no Part B MPFS allowed charges.

Figure 6. Distribution of Satisfactorily Reported Individual Measures for the Physician Quality Reporting System (2011)



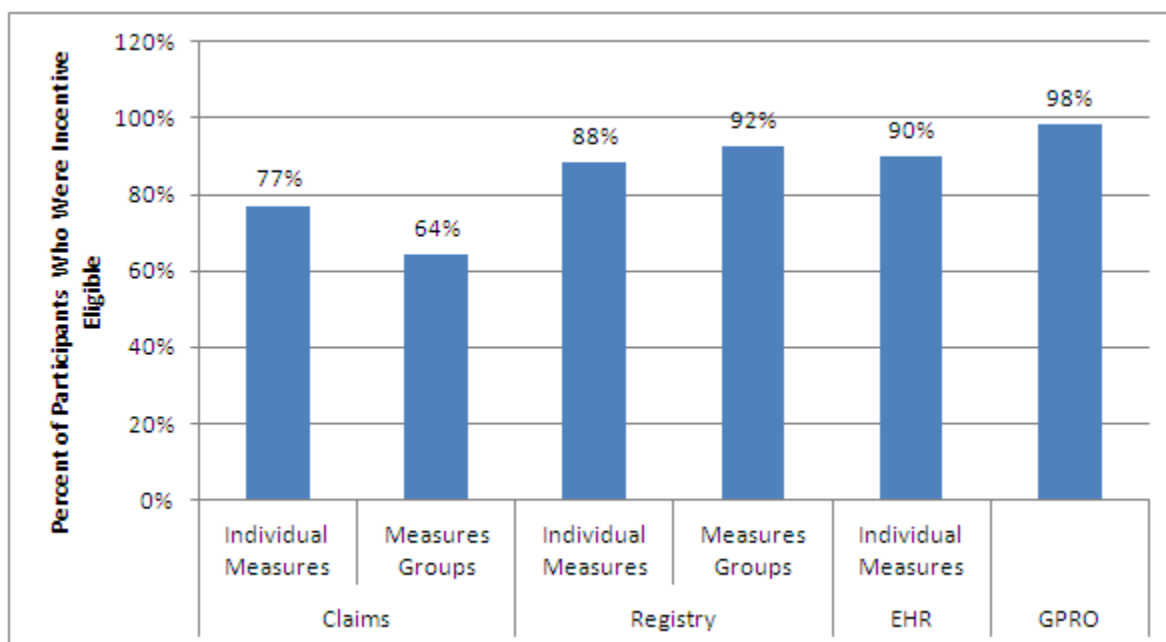
Note for Figure 6: Satisfactory reporting required reporting at least 50 percent of eligible instances for claims-based reporting and 80 percent of eligible instances for registry-based reporting.

Incentive Eligibility

- Across all reporting options, more than eight in ten participants (83 percent) in the 2011 Physician Quality Reporting System met the criteria for incentive eligibility.⁴
 - Incentive eligibility rates increased every year since the program began in 2007, when the rate was 53 percent.
- Over three-quarters (77 percent) of eligible professionals who participated by reporting individual measures through the claims mechanism in the 2011 Physician Quality Reporting System earned an incentive (Figure 7).
 - The GPRO reporting option, registry-based reporting mechanism, and EHR reporting mechanism had the highest incentive eligibility rates.

⁴ The Data and Methods section in the Appendix describes the criteria to qualify for an incentive payment under both programs.

Figure 7. Incentive Eligibility Rate by the Physician Quality Reporting System Reporting Mechanism (2011)



Note for Figure 7: Individual eligible professionals could be counted under more than one method if they participated and were incentive eligible under more than one method.

- Over six out of ten (62 percent) eligible professionals who participated in the 2011 eRx Incentive Program qualified for an incentive (including eligible professionals who were part of a group practice that reported under the GPRO). The incentive eligibility rate increased modestly from roughly 58 percent in 2010.
- More than six out of ten (63 percent) eligible professionals that participated in both the Physician Quality Reporting System and the eRx Incentive Program qualified for an incentive through both programs (Table 4).
 - For example, 137,443 eligible professionals participated in both the Physician Quality Reporting System and the eRx Incentive Program in 2011, and among these, 87,164 were incentive eligible for both programs.

Table 4. Eligible Professionals and Practices Participating in Both the Physician Quality Reporting System and eRx Incentive Program (2010 to 2012*)

	Eligible Professionals in 2010 ¹	Eligible Professionals in 2011 ²	Eligible Professionals in 2012	Practices in 2010	Practices in 2011	Practices in 2012
Participated in Either Program	322,989	465,361	381,815	45,316	80,983	80,427
Eligible for Both Programs	202,386	327,111	265,287	39,391	74,279	74,082
Participated in Both Programs	77,114	137,443	72,658	12,780	22,269	17,968
Percent Participated who were Eligible for Both Programs	38.1%	42.0%	27.4%	32.4%	30.0%	24.3%
Incentive Eligible for Both Programs	44,861	87,164	--	6,859	13,106	--
Percent Incentive Eligible who Participated in Both Programs	58.2%	63.4%	--	53.7%	58.9%	--
Total Payments ³	\$263,303,295	\$237,195,255	--	\$379,693,669	\$336,049,445	--
Average Payments ³	\$7,905	\$3,919	--	\$55,357	\$25,641	--

* Results for 2012 are preliminary only; incentive information was not yet available at the time this report was prepared. Note that for total and average payments, eligible professional level results are for individual participants only whereas practice level results include individual participants, summarized at the practice level, as well as practices who participated under the GPRO.

¹ Eligible professional counts for 2010 include 25,407 who participated under the Physician Quality Reporting System GPRO and 18,706 who participated under the eRx Incentive Program GPRO; 12,193 were participants in both programs. ² Eligible professional counts for 2011 include 41,803 who participated under the Physician Quality Reporting System GPRO and 38,262 participated under the eRx Incentive Program GPRO; 30,876 were encompassed in both programs. ³ The payment amounts are among those who qualified for an incentive through individual participation options in both programs.

In summary, the number of eligible professionals who participated and earned an incentive in the Physician Quality Reporting System and the eRx Incentive Program continued to grow in the 2011 program year. Most eligible professionals who participated in either program were successful reporters and qualified for an incentive payment. The 2011 incentive eligibility rate among participants was 83 percent and 62 percent, respectively, for the Physician Quality Reporting System and the eRx Incentive Program. Among all eligible professionals who could have participated in the program (including those in group practices that participated under the GPRO), 24 percent earned an incentive for the Physician Quality Reporting System and 23 percent earned an incentive for the eRx Incentive Program (data not shown).

Table 5. Eligible Professionals' and Practices' Reporting Results for the Physician Quality Reporting System and eRx Incentive Program (2011)

	Eligible Professionals in PQRS	Eligible Practices in PQRS	Eligible Professionals in eRx	Eligible Practices in eRx
Eligible	1,101,773	301,922	748,224	229,421
Participated via Any Method	320,422	36,686	282,382	66,560
Participated via Claims	230,501	31,017	242,691	66,200
Participated via Registry	62,883	7,572	17,272	1,498
Participated via EHR	560	164	104	66
Participated via GPRO I	39,404	54	34,943	43
Participated via GPRO II	789	38	674	31
Incentive Eligible	266,521	26,515	174,189	43,132
Total Payments	\$240,430,938	\$261,733,236	\$268,349,737	\$285,049,103
Average Payments	\$1,059	\$9,863	\$1,912	\$6,609

Note for Table 5: Some eligible professionals participated in more than one reporting method. Eligible professional-level participation and incentive eligible counts include those who were part of a group practice that participated under the GPRO, while total and average payment amounts exclude those who participated under the GPRO.

Between both programs, incentive payments totaled \$546,782,339 in 2011. The Physician Quality Reporting System collected quality information on nearly 14 million Medicare beneficiaries. Moreover, the 2011 eRx Incentive Program revealed that over 282,000 eligible professionals and 66,000 practices implemented and used qualified electronic prescribing systems.

2012 eRx Payment Adjustment

- 135,931 eligible professionals (including those participating under the GPRO) were subject to the 2012 eRx payment adjustment because they either did not qualify for an exemption, meet exclusion criteria for the adjustment, or did not meet eRx reporting requirements in the first half of 2011.
 - Over 80 percent of those subject to the payment adjustment did not participate in the eRx program at all.
- However, 543,545 eligible professionals were not subject to the payment adjustment for the following reasons:
 - 39 percent did not have enough eligible cases; 25 percent were not in a qualifying specialty (MD/DO, podiatrist, nurse practitioner, or physician assistant); and two percent did not meet the 10 percent limitation threshold.
 - Almost 30 percent reported on the required number of eRx cases.
 - Six percent received a significant hardship exemption; most of which were submitted via the Communication Support Page (CSP).

II. INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) implemented two pay-for-reporting programs for eligible professionals. The Physician Quality Reporting System, authorized under Section 101(b) of division B of the TRHCA of 2006 (Public Law 109-423; 120 Stat. 2975) entered its fifth year in 2011 and has grown substantially from its inception in 2007. The Electronic Prescribing (eRx) Incentive Program, authorized under section 132 of the MIPPA, began in 2009. Currently, these programs reward eligible professionals—determined based on a percentage of the professional’s estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional during the applicable reporting period—and provide for payment adjustments based on whether eligible professionals meet applicable requirements for reporting information on standardized clinical quality measures.

This report summarizes the experience of eligible professionals who participated in these programs in 2011 and provides historical trends. Section III presents detailed findings for the Physician Quality Reporting System and Section IV presents similar information for the eRx Incentive Program. Sections V and VI describe information about feedback reports available under the Physician Quality Reporting System and the eRx Incentive Program and the services available from the Help Desk. Section VII provides overall conclusions. The Appendix is a separate document for interested readers, which contains additional descriptions of data and methods, as well as detailed tables of results.

This report uses the term “eligible professional” to describe physicians and other health care professionals who could participate in the Physician Quality Reporting System and eRx Incentive Program. The health care professionals who are eligible to participate in the Physician Quality Reporting System and eRx Incentive Program are precisely defined on the CMS website.⁵ In general, this includes professionals who furnish MPFS covered services to Medicare Part B (including Railroad Retirement Board and Medicare Secondary Payer) beneficiaries for whom selected Physician Quality Reporting System measure(s) or the eRx Incentive Program measure are applicable.

The unit of analysis for describing eligible professionals was a combination of a professional’s National Provider Identifier (NPI) number and the Taxpayer Identification Number (TIN) under which they billed for services; this is commonly referred to as a “TIN/NPI” (please see the Appendix for more detail). Findings reported at the practice level include both eligible professionals participating individually, summarized at the practice level, as well as practices that participated through the group practice reporting option (GPRO). While the GPRO is not an individual participation option, the participation information from the GPRO was sometimes combined with individual participation options to describe the total number of individual eligible professionals, including those who are part of group practices that report under the GPRO.

⁵ <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS>

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive>

III. PHYSICIAN QUALITY REPORTING SYSTEM

A. Background

Program Description

The Physician Quality Reporting System is part of an overall effort to move toward a value-based purchasing (VBP) system that aims to reward the value of care provided, rather than the quantity of services. To this end, the Physician Quality Reporting System measures are intended to define, standardize and improve the quality of health care. An incentive and payment adjustment, applicable to professionals who satisfy the criteria for reporting quality data under the Physician Quality Reporting System, are intended to encourage professionals to adopt evidence-based, outcomes-driven healthcare delivery practices.

The authorizing legislation for the program was originally set forth in Section 101(b) of division B (Medicare Improvements and Extension Act of 2006 [MIEA]) of the TRHCA, which was enacted on December 20, 2006. CMS initially referred to the Physician Quality Reporting System as the Physician Quality Reporting Initiative or PQRI.

Section 101(c) of MIEA-TRHCA established a financial incentive for professionals to participate in a voluntary quality reporting program. An eligible professional who chose to participate in the 2007 Physician Quality Reporting System and satisfied the reporting criteria on a set of quality measures was eligible for an incentive, subject to a cap, of 1.5 percent of the total estimated Part B MPFS charges for covered professional services furnished by the eligible professional during the reporting period.

Program Evolution

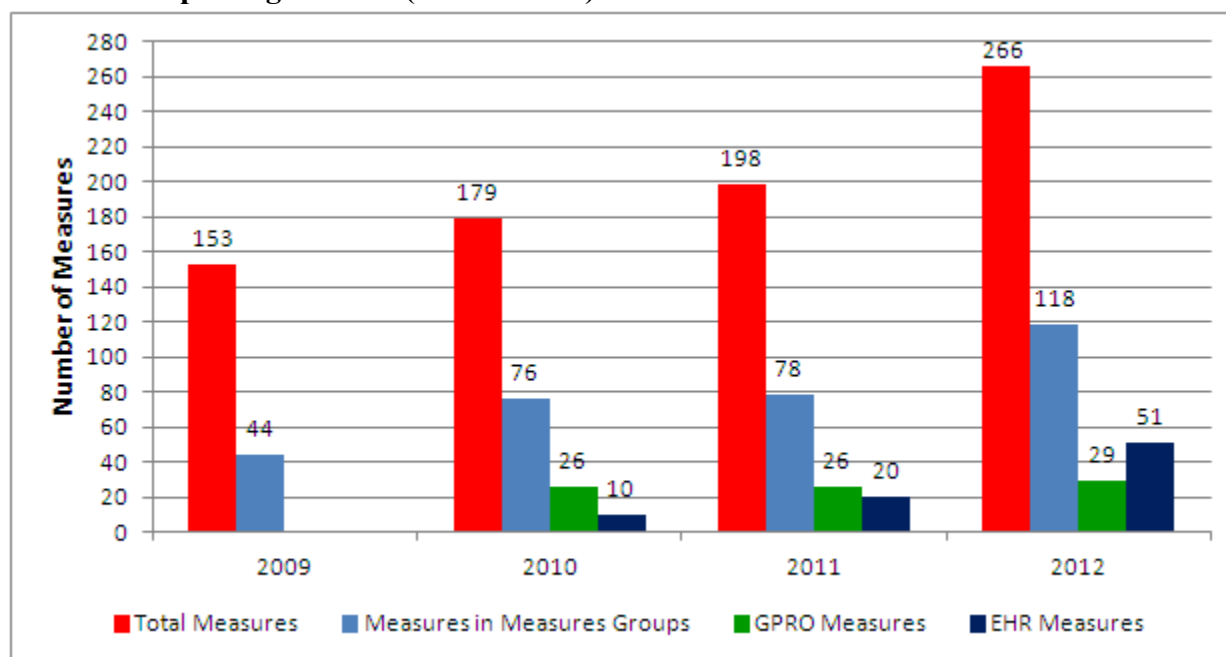
Measures for the 2007 program were defined by the TRHCA as quality measures that were developed under the Physician Voluntary Reporting Program (PVRP) and published on the CMS website as of the date of enactment of the TRHCA. The statute also provided that measures could be changed by the Secretary through a consensus-based process if such changes were published on the CMS website by a specified date. A portion of the 74 measures and their specifications were developed by the American Medical Association-Physician Consortium for Performance Improvement (AMA-PCPI), physician specialty organizations, and the National Committee for Quality Assurance (NCQA). The AMA-PCPI collaborated with CMS on defining reporting specifications for measures used in the 2007 program and developed instructions on how data would be captured through a claims-based reporting process using quality data codes (QDCs) based on either Current Procedural Terminology (CPT) II codes or G-codes. QDCs indicate performance of a quality action, non-performance of the action, or an exclusion from performing the action. The Appendix to this report provides a description of how eligible professionals submit quality measure data to CMS.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), enacted on December 29, 2007 (Pub. Law 110-173), extended the quality reporting system through 2008 and 2009. The MMSEA authorized incentive payments for 2008 and removed the cap on the total earned incentive amount previously mandated by TRHCA. Additionally, the MMSEA required that CMS establish alternative reporting periods, criteria for reporting groups of clinically-related

measures, and collecting quality information through a clinical data registry. Registries do not require QDCs to accept clinical data. In 2009 and 2010, the applicable quality percent for the PQRS incentive was set at two percent; it was decreased to one percent in the 2011 program. The Affordable Care Act makes a number of changes to the Physician Quality Reporting System, including authorizing incentive payments through 2014 and requiring a penalty, beginning in 2015, for eligible professionals who do not satisfactorily report. The Affordable Care Act also authorizes an additional incentive (the applicable quality percent under the PQRS is increased by 0.5 percent) for 2011 through 2014 for eligible professionals who satisfactorily report data on quality measures under the PQRS and satisfy certain requirements related to participation in a Maintenance of Certification Program (MOCP).

CMS has continued to expand the number of measures and reporting options for the Physician Quality Reporting System each year (Figure 8). In 2010, 179 measures were available to report. In 2011, a total of 198 measures could be reported, including 194 individual measures, and 78 measures group measures (four measures reportable only through measures groups). The 2012 program year will expand the measure set to 266 total measures. Appendix Table A1 lists all measures that could be reported in the PQRS program during 2011.

Figure 8. Number of Individual Measures in the Physician Quality Reporting System by Reporting Method (2009 to 2012)



Note for Figure 8: Categories are not mutually exclusive; for example, an individual measure can also be part of a measures group. GPRO counts in 2011 do not include the GPRO II reporting option.

In addition to the growth of individual measures, measures groups were introduced in the 2008 program year and expanded each year thereafter. Measures groups are a subset of four or more clinically-related measures. The 2009 program retained three of the four measures groups from 2008—diabetes mellitus (six measures), chronic kidney disease (CKD) (five measures), and preventive care (nine measures)—and retired one group (ESRD). The following measures groups

were added for 2009: rheumatoid arthritis (RA) (six measures), coronary artery bypass graft (CABG) surgery (ten measures), perioperative care (four measures), and back pain (four measures). While both the claims and registry reporting options had a measures group option, the CABG measures group could only be reported through a registry. The measures in the back pain measures group are only reported as a group and not as individual measures. Beginning in 2009, CMS introduced a new QDC that allowed eligible professionals reporting on measures groups to use a single code to indicate if all recommended quality actions were performed for each measure in the group. That is, eligible professionals could report a single QDC—referred to as a composite G-code—for the entire measures group. Before this code existed, eligible professionals reported one QDC for each measure within the measures group.

Beginning in 2010, the following three measures groups were available for reporting through claims or registries: ischemic vascular disease (IVD) (six measures), hepatitis C (eight measures), and community-acquired pneumonia (CAP) (four measures). The 2010 program also introduced three new measures groups reportable only through a registry: coronary artery disease (CAD) (five measures), heart failure (six measures), and HIV/AIDS (eight measures). Moreover, in an effort to simplify measures group reporting, the 2009 program year requirement to report consecutive patients was removed. That is, beginning in the 2010 program year, eligible professionals could report a measures group measure on 30 non-consecutive beneficiaries—appropriate for the measures group—during the reporting period. This change applied to reporting measures groups through both claims and a registry. In 2011, one measures group reportable through claims or a registry was added—asthma (four measures).

In addition to expanding the available measures, CMS continued to expand and refine the avenues for participation in the Physician Quality Reporting System in recent years, as shown in Tables 6 and 7. For example, the GPRO and EHR reporting mechanism added in 2010 offered new opportunities for participation; like registries, these options did not rely on reporting QDCs. CMS further expanded the program in 2011 by adding the GPRO II reporting option for smaller practices (i.e., between two and 199 eligible professionals), and the original GPRO option was now called GPRO I. In 2012, GPRO I and GPRO II were replaced with two different reporting options for large and small group practices under the GPRO, and the cutoffs became 25 to 99 eligible professionals for small practices and 100 or more eligible professionals for large GPRO practices.

Table 6. Summary of Reporting Mechanisms in the Physician Quality Reporting System (2007 to 2012)

Reporting Mechanisms	2007	2008	2009	2010	2011	2012
Claims Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes
Claims Measures Groups	No	Yes	Yes	Yes	Yes	Yes
Registry Individual Measures	No	Yes	Yes	Yes	Yes	Yes
Registry Measures Groups	No	Yes	Yes	Yes	Yes	Yes
Electronic Health Record (EHR)	No	No	No	Yes	Yes	Yes
Group Practice Reporting Option (GPRO) ¹	No	No	No	Yes	Yes	Yes

Note for Table 6: ¹GPRO was a reporting option for practices with 200 or more professionals in 2010; a GPRO tool was used to report data. In 2011, the GPRO option from 2010 was referred to as GPRO I and practices reported data through a web interface; the GPRO II option was added for practices with 2 to 199 professionals and these

practices could report through claims or registry mechanisms. In 2012, GPRO I and GPRO II were replaced with reporting options for large and small group practices; these practices report through a web interface.

Table 7. Summary of Physician Quality Reporting System Incentives, Measures and Reporting Criteria (2010 to 2012)⁶

	2010	2011	2012
Applicable Quality Percent*	2%	1%	0.5%
Number of Measures and Measures Groups	179 Total Measures 13 Measures groups	198 Total Measures 14 Measures groups	266 Total Measures 22 Measures groups
Individual Measures Reporting Criteria	<ul style="list-style-type: none"> • Claims: 3 measures (or 1-2 measures subject to MAV) and 80% of eligible instances; • Registry&EHR: a minimum of 3 measures and 80% of eligible instances 	<ul style="list-style-type: none"> • Claims: 3 measures (or 1-2 measures subject to MAV) and 50% of eligible instances; • Registry&EHR: a minimum of 3 measures and 80% of eligible instances 	<ul style="list-style-type: none"> • Claims: 3 measures (or 1-2 measures subject to MAV) and 50% of eligible instances • Registry&EHR: a minimum of 3 measures and 80% of eligible instances
Measures Group (MG) Reporting Criteria **	Report on all measures in at least one MG for: <ul style="list-style-type: none"> • 80% eligible Medicare patients (min of 8 or 15 patients) via claims or registry, or • 30 patients (non-Medicare patients accepted for registry-based reporting only) via claims or registry 	Report on all measures in at least one MG for: <ul style="list-style-type: none"> • 50% eligible Medicare patients (min of 8 or 15 patients) via Claims, or • 80% eligible Medicare patients (min of 8 or 15 patients) via Registry, or • 30 patients via claims or registry 	Report on all measures in at least one MG for: <ul style="list-style-type: none"> • 50% eligible Medicare patients (min of 8 or 15 patients) via Claims, or • 80% eligible Medicare patients (min of 8 or 15 patients) via Registry, or • 30 patients via claims or registry

Notes for Table 7: *Applicable Quality Percent is applied to estimated allowed charges for covered professional services furnished by the eligible professional in the applicable reporting period. **minimums of 8 and 15 patients apply to 6-month and 12-month reporting periods, respectively.

⁶ For further details, see the Final Rule at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS1240932.html>

Reporting quality information for practices who participated in PQRS through the GPRO I differs from reporting for eligible professionals who participated individually. A group practice that wanted to participate through the GPRO nominated their practice. Among practices that met requirements and were approved to participate through GPRO I, CMS provided a web interface containing a sample of patients with select patient demographic and utilization characteristics. The practices were responsible for completing data fields to report specific quality actions for 26 measures for the selected patients. This database included four disease modules (i.e., diabetes mellitus, heart failure, coronary artery disease, and hypertension) and four preventive care measures. Practices had to report a minimum of 411 patients per measure in the disease module and preventive care measure or all eligible patients if fewer were available. In 2011, practices using the new GPRO II option for smaller practices reported data through the claims or registry mechanisms.

In addition to expanding mechanisms through which eligible professionals can participate, the reporting criterion for receiving an incentive was simplified in 2011. That is, the 2011 program year required eligible professionals who reported individual measures or measures groups through claims to report at least 50 percent of eligible instances, a decrease from 80 percent in 2010. Otherwise, basic incentive eligibility rules have remained consistent since 2010. Moreover, the Measure Applicability Validation (MAV) process continued, which allows eligible professionals who were eligible for fewer measures (e.g., less than three), to qualify for an incentive.

As in prior years, the MAV was applied for eligible professionals who satisfied the reporting criteria (e.g., 50 percent for claims-based measures in 2011) for one or two individual measures and did not report other measures. The process then determines whether they could have reported additional clinically-related measures through two tests. First, the clinical relation test checks for any eligible instances on related measures. Second, the minimum threshold test checks for a certain number of eligible instances for those measures the eligible professional could have reported based on the clinical relation test.⁷ Eligible professionals who satisfied the reporting criteria for one or two individual measures and did not satisfy the MAV process did not earn an incentive because they could have reported additional measures. Conversely, eligible professionals who satisfied both the reporting criteria for one or two individual measures and the MAV process could qualify for an incentive.

Finally, as shown in Table 7, for eligible professionals who earned an incentive, the payment in the 2011 program year was one percent of total estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional in the applicable reporting period. The incentive percentage will be 0.5 percent for the 2012 Physician Quality Reporting System. Beginning in 2011, eligible professionals had the opportunity to receive an additional incentive of 0.5 percent by working with a Maintenance of Certification entity and by meeting all of the following requirements:

⁷ The threshold for eligible instances was 50 in 2007, 30 in 2008, 15 in 2009, and 15 for the 12-month method and 8 for the 6-month method in both 2010 and 2011.

- Satisfy the reporting criteria, without regard to option, on quality measures under the Physician Quality Reporting System, for a 12-month reporting period either individually or as part of a selected group practice, AND
- More frequently than is required to qualify for or maintain board certification, participate in a MOCP, AND
- More frequently than is required to qualify for or maintain board certification, successfully complete a qualified MOCP practice assessment.

B. Incentive Payments

The incentive for the 2011 Physician Quality Reporting System was equal to one percent of estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional (professional and technical services) during the reporting period. Overall, a total of \$240,430,938 in incentive payments were distributed to 227,061 individually-participating eligible professionals for the 2011 program year, with an average payment of \$1,059.^{8,9} A total of \$261,733,236 was paid in incentives to 26,515 practices (including individually participating eligible professionals, summarized at the practice level, as well as practices that received an incentive under the GPRO), with an average incentive payment of \$9,863 per practice for the 2011 program year.

As seen in Figures 1 and 2, the average incentive and the numbers of eligible professionals and practices earning incentives grew between 2008 and 2011. Decreases in the average incentive payments to eligible professionals and practices were driven by the decrease in the applicable quality incentive percentage from two percent to one percent in 2011.

Incentive Payments by Specialty

Total incentive payments by specialty under the Physician Quality Reporting System are determined both by the number of eligible professionals within the specialty who qualify for an incentive and by total Part B MPFS allowed charges for covered professional services furnished by those eligible professionals during the applicable reporting period. Therefore, variations in total incentive payments by specialty reflect differences both in incentive eligibility rates (number of eligible professionals who received an incentive divided by the number of eligible professionals who participated) and in Part B MPFS allowed charges for covered professional services furnished by the eligible professionals during the applicable reporting period. Appendix Table A2 displays the distribution of incentive payments by specialty.

⁸ Eligible professionals who met incentive eligibility criteria but had no Part B MPFS charges for covered professional services furnished by the eligible professional during the reporting period had an incentive amount of \$0.00. These eligible professionals were not included in counts of those whom we paid an incentive in this report. For additional explanation, please see the Appendix.

⁹ Another 40,193 eligible professionals were encompassed by the 92 group practices that participated under the GPRO I and GPRO II in the Physician Quality Reporting System.

Appendix Table A3 presents the average potential incentive that could have been earned if 100 percent of individual eligible professionals participated and qualified for an incentive during a 12-month reporting period. This was calculated by summing the total 2011 Part B MPFS allowed charges for covered professional services furnished during the 12-month reporting period by all individual eligible professionals who could have participated in 2011, dividing by the number of those individual eligible professionals, and taking one percent of this value. Overall, the average potential incentive was over \$775 for all MD/DO and other eligible professional specialties, but exceeded \$2,000 for six specialties.

Payments for the Maintenance of Certification Program (MOCP)

Beginning in 2011, eligible professionals who qualified for a Physician Quality Reporting System incentive could earn an additional incentive of 0.5 percent of total Part B MPFS allowed charges by meeting reporting and participation requirements related to MOCP programs. To be eligible for the additional “MOCP incentive,” incentive eligible professionals had to be a physician. For the purposes of this program, the term “physician” was limited to doctors of medicine; doctors of osteopathy; doctors of dental surgery or of dental medicine; doctors of podiatric medicine; doctors of optometry; or doctors of chiropractic. Seven boards were qualified for the 2011 Physician Quality Reporting System MOCP incentive: the American Board of Allergy and Immunology, the American Board of Dermatology, the American Board of Neurological Surgery, the American Board of Nuclear Medicine, the American Board of Optometry, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, and the American Board of Radiology.

Tables 8 and 9 show MOCP incentives earned by participation method and specialty. Most eligible professionals earning an MOCP incentive payment qualified for an incentive for the Physician Quality Reporting System through the claims reporting mechanism (Table 8). In the 2011 program, 942 eligible professionals earned an MOCP incentive payment; the majority of those earning an incentive payment were either radiologists (84 percent) or interventional radiologists (five percent).

Table 8. Physician Quality Reporting System MOCP Incentive Amounts by Participation Mechanism or Option (2011)

	Number Eligible for MOCP Incentive	MOCP Median Incentive Payment	MOCP Mean Incentive Payment	MOCP Total Incentive Payments
Eligible Professional Level	--	--	--	--
Claims	811	\$661.53	\$849.24	\$688,735.14
Registry	166	\$1,215.97	\$1,803.33	\$299,352.71
EHR	0	n/a	n/a	n/a
Total (Unduplicated)	942	\$739.80	\$1,008.78	\$950,275.21
Practice Level	--	--	--	--
Claims	208	\$939.49	\$3,593.00	\$747,343.95
Registry	62	\$2,274.20	\$5,131.37	\$318,144.68
EHR	0	n/a	n/a	n/a
Group Practice Reporting Option (GPRO I)	11	\$534.17	\$797.06	\$8,767.64
Group Practice Reporting Option II (GPRO II)	0	n/a	n/a	n/a
Total (Unduplicated)	241	\$1,148.15	\$3,979.43	\$959,042.85

Table 9. Eligible Professional MOCP Incentive Amounts by Specialty for Individual Participation Options (2011)

Specialty	Number of Eligible Professionals who Earned MOCP Incentive	Total MOCP Incentive Payments
MD/DO	880	\$890,658.59
Dermatology	33	\$109,201.94
Interventional Radiologist	51	\$48,227.65
Nuclear Medicine	4	\$2,463.56
Plastic Surgery	1	\$2,490.58
Radiologist	791	\$728,274.86
Other Eligible Professionals	62	\$59,616.62
Optometry	22	\$12,097.05
Other Eligible Professional	12	\$29,877.15
Podiatrist	28	\$17,642.41
Total (Unduplicated)	942	\$950,275.21

Note for Table 9: Specialties not shown in Table 9 did not earn a MOCP incentive payment.

C. Participation

How to Participate

CMS provides multiple resources on the [Physician Quality Reporting System website](#) to assist eligible professionals who choose to participate in the program. The *2011 Implementation Guide* gave guidance on how to determine which measures to report, the reporting method, and claims-based reporting principles. CMS also provided Frequently Asked Questions (FAQ's) covering a wide range of topics regarding the program.

In 2011, there were 11 individual participant options and three group options for submitting data to the Physician Quality Reporting System:

1. Claims-Based Individual Measures 12-months. Eligible professionals could report QDCs for 131 individual measures via claims. To qualify for an incentive, eligible professionals had to report at least 50 percent of eligible instances on at least three measures (or one or two measures, subject to the measure applicability validation [MAV] review as described above); the 12-month period was from January 1 to December 31, 2011.
2. Claims-Based Individual Measures 6-months. This option had the same reporting criteria as the 12-months claims-based individual measures option, except with a 6-month reporting period from July 1 to December 31, 2011.
3. Claims-Based Measures Groups 50 Percent Patients 12-months. Eligible professionals could report on applicable measures within any of 10 measures groups available for claims reporting. To be incentive eligible, eligible professionals had to report all applicable measures for at least one measures group on at least 50 percent of their applicable Medicare Part B fee-for-service (FFS) patients; a minimum of 15 patients was required. The 12-month period was from January 1 to December 31, 2011.
4. Claims-Based Measures Groups 50 Percent Patients 6-months. This option had the same reporting criteria as the preceding claims-based measures groups with the following two exceptions: a minimum of eight patients and a six-month reporting period from July 1 to December 31, 2011.
5. Claims-Based Measures Group - 30 Patients 12-months. Eligible professionals could report all applicable measures within any of the 10 measures groups available for claims reporting. To be incentive eligible, eligible professionals had to report all applicable measures for at least one measures group on at least 30 Medicare Part B FFS patients; the 12-month reporting period was from January 1 to December 31, 2011.
6. Registry-Based Reporting - Individual Measures 12-months. Eligible professionals could submit data on 186 measures through a qualified registry. To be incentive eligible, eligible professionals had to report on at least three measures and report each measure in at least 80 percent of eligible instances during the 12-month period from January 1 to December 31, 2011.

7. Registry-Based Reporting - Individual Measures 6-months. This option had the same reporting criteria as the preceding registry-based individual measures option except with a 6-month reporting period from July 1 to December 31, 2011.
8. Registry-Based Reporting – Measures Groups 80 Percent Patients 12-months. Eligible professionals could submit data for 14 measures groups through a qualified registry. To be incentive eligible, eligible professionals had to report all applicable measures for at least one measures group on at least 80 percent of applicable Medicare Part B FFS patients seen during the reporting period; a minimum of 15 patients was required. The 12-month period was from January 1 to December 31, 2011.
9. Registry-Based Reporting – Measures Groups 80 Percent Patients 6-months. This option had the same reporting criteria as the preceding registry-based measures groups 80 percent option with the following two exceptions: a minimum of eight Medicare Part B FFS patients and a 6-month period from July 1 to December 31, 2011.
10. Registry-Based Reporting – Measures Groups 30 Patients 12-months. Eligible professionals could submit data through a qualified registry. To be incentive eligible, eligible professionals had to report all applicable measures for at least one measures group on at least 30 patients; patients could only be Medicare Part B FFS. The 12-month reporting period was January 1 to December 31, 2011.
11. Electronic Health Records 12-months. Eligible professionals could submit data through a qualified EHR vendor. To be incentive eligible, eligible professionals had to report at least three of 20 available EHR measures for at least 80 percent of applicable Medicare Part B FFS patients seen by the eligible professional during the 12-month reporting period from January 1 to December 31, 2011.
12. GPRO I. Large practices (200 or more eligible professionals) that self-nominated and were selected by CMS had to complete all applicable 26 measures in the GPRO web interface for a pre-populated patient sample of 411 patients. The 12-month reporting period was January 1 to December 31, 2011
13. GPRO II – Claims-Based Reporting. GPRO II practices were self-nominated and selected by CMS. GPRO II practices had to submit a specified number of patients for one to four measures groups as well as at least 50 percent of Medicare Part B FFS patients for three to six individual measures not in measures groups reported for the 12-month period January 1 through December 31, 2011. These requirements varied by practice size/GPRO II tier:
 - a. 2 to 10 NPIs: report at least one measures group for at least 35 patients (count) and at least three individual measures for 50 percent of patients.
 - b. 11 to 25 NPIs: report at least one measures group for at least 50 patients (count) and at least three individual measures for 50 percent of patients.
 - c. 26-50 NPIs: report at least two measures groups for at least 50 patients (count) and at least four individual measures for 50 percent of patients.

- d. 51-100 NPIs: report at least three measures groups for at least 60 patients (count) and at least five individual measures for 50 percent of patients.
 - e. 101-199 NPIs: report at least four measures groups for at least 100 patients (count) and at least six individual measures for 50 percent of patients.
14. GPRO II – Registry-Based Reporting. Applies to GPRO II practices and uses the same reporting criteria as the Claims Based Reporting option for GPRO II. However, this approach requires at least 80 percent of Medicare Part B FFS patients for the individual measures required in the Claims-Based Reporting option for GPRO II, submitted via a qualified registry.

Participation Results

In 2011, there were 1,101,773 professionals eligible to participate in the Physician Quality Reporting System, including eligible professionals who were part of a group practice that participated under the GPRO.¹⁰ Appendix Table A4 presents characteristics of eligible professionals that were eligible to participate in the 2011 Physician Quality Reporting System. Most eligible professionals were in solo or relatively small practices and were in a primary care or other non-surgical specialty.

Appendix Table A5 presents the number of eligible professionals who could have participated in the Physician Quality Reporting System through any reporting option by specialty for the 2008 to 2011 program years. Internal Medicine and Family Practice had the largest number of eligible professionals who could have participated in the program (over 94,000 each). Almost all specialties have seen an increase in the number eligible to participate in the program.

As shown in Figure 4 above, each year of program operation has seen growth in participation across all reporting options. Overall, 280,229 eligible professionals (26 percent of those eligible) participated individually in the 2011 Physician Quality Reporting System. In addition, 39,404 eligible professionals within 54 participating GPRO I practices and 789 eligible professionals within 38 GPRO II practices participated. Including those in group practices that participated under the GPRO, the overall participation rate was 29 percent, and the number participating increased 19 percent from 2010.

Eligible professionals who chose to participate in the 2011 Physician Quality Reporting System using the registry or EHR-based reporting options contacted the CMS-qualified registries or EHR vendors listed in the posted CMS qualified lists.¹¹ In 2011, there were 93 qualified registries, 87 of which submitted quality measure information. There were 27 EHR vendors qualified by CMS to submit EHR data, but only seven of these vendors submitted data.

Over three-quarters of individual participants used claims-based reporting and 18 percent used registry reporting, although registry reporting has increased every year since 2008 (Appendix Table A6). Only about five percent used multiple reporting mechanisms. The most common

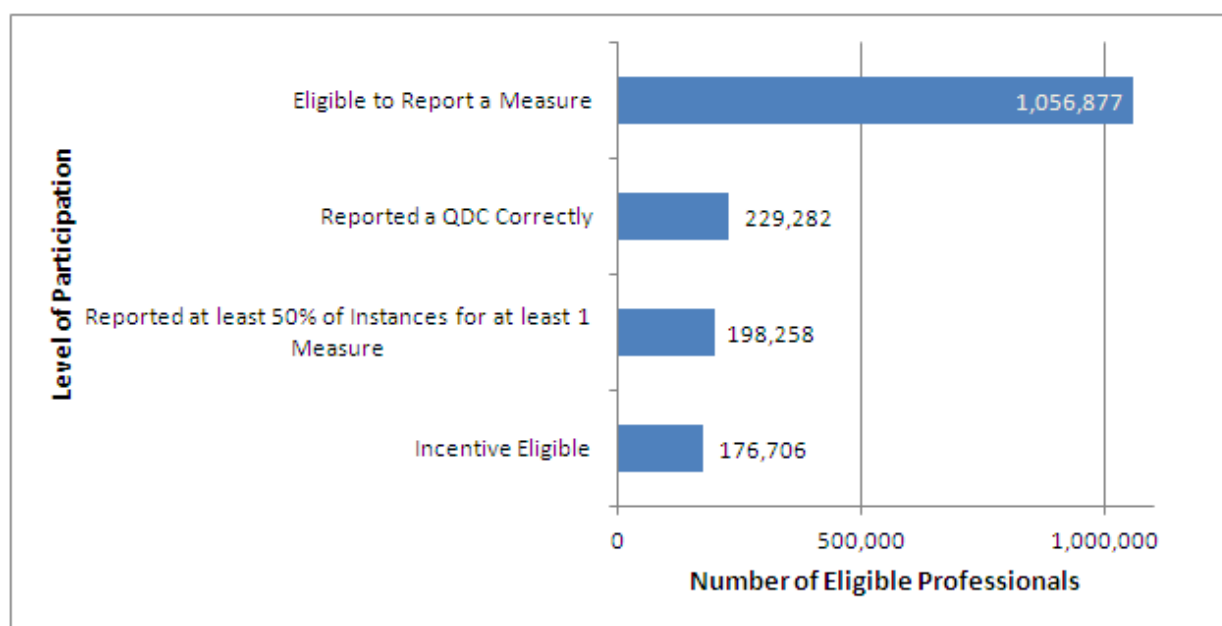
¹⁰ The Appendix provides definitions of program eligibility, program participation and incentive eligibility.

¹¹ <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/2011-Physician-Quality-Reporting-System.html>

combination was claims and registry reporting; 4.8 percent of individual eligible professionals used both of these mechanisms and another 0.1 percent used claims and EHR (data not shown). Appendix Table A6 shows that participation rates also varied by reporting option and ranged from 21 percent of all eligible professionals reporting claims-based individual measures to close to zero percent of all eligible professionals participating via EHR or GPRO II.¹²

Figure 9 summarizes participation through the claims-based individual measure reporting mechanism in 2011. While over one million professionals were eligible to participate in the Physician Quality Reporting System in 2011, about one in five professionals participated by submitting at least one QDC without error (22 percent). Among all eligible professionals attempting to submit a QDC (N=238,125), about four percent submitted all invalid QDCs (N=8,843) (data not shown). Ultimately, about 17 percent of professionals eligible to submit claims-based individual measures to the Physician Quality Reporting System qualified for an incentive in 2011. Incentive eligibility and payments are described in greater detail in subsequent sections of this report.

Figure 9. Summary of Individual Measures Reported through the Claims Mechanism for the Physician Quality Reporting System (2011)



Note for Figure 9: Results included both 12-month and 6-month individual measures claims options.

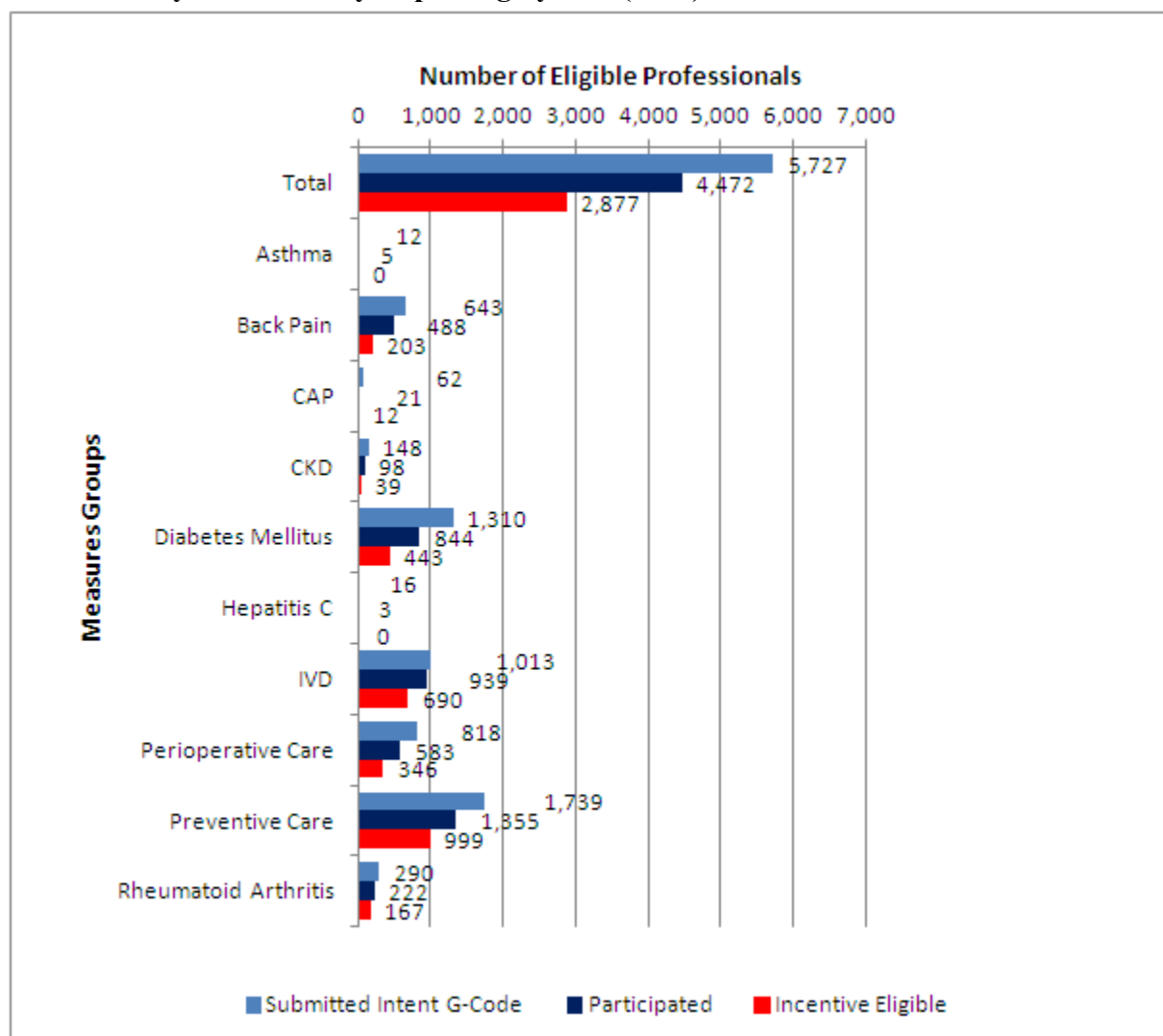
Use of Measures Groups and Registries

The number of measures groups available for reporting under the Physician Quality Reporting System expanded from four to 14 between 2008 and 2011. The number of eligible professionals who participated via claims-based measures groups reporting mechanism grew more than three-fold between 2008 and 2011 (Appendix Table A9). Figure 10 shows the number of eligible

¹² There were 560 eligible professionals who participated via EHR, and 789 eligible professionals participating through the GPRO II, which rounds down to 0 percent.

professionals signaling their intention to participate in the claims-based measures group reporting option by submitting intent G-codes, submitting QDCs, and attaining incentive eligibility within each claims-based measures group. The preventive care measures group was reported the most by eligible professionals and was associated with the most eligible professionals earning an incentive payment.

Figure 10. Summary of Measures Groups Reported through the Claims Mechanism for the Physician Quality Reporting System (2011)



Note for Figure 10: CAP=Community-Acquired Pneumonia, CKD=Chronic Kidney Disease, and IVD=Ischemic Vascular Disease.

Participation in the registry-based measures group reporting option grew at an even more rapid rate over the same period; the number of eligible professionals participating in registry measures groups increased more than four-fold between 2008 and 2011, although most of this increase occurred between 2008 and 2010 (Appendix Table A11). The preventive care and diabetes measures groups were reported by the largest number of eligible professionals via registry. These two measures groups are broadly applicable to the Medicare population and are applicable to two

of the most common specialties (Family Medicine and Internal Medicine) reporting measures groups.

The use of registry reporting also increased from 2008 to 2011. In 2008, 31 qualified registries submitted data on behalf of eligible professionals, and in 2011, 87 qualified registries submitted data. Table 10 displays the registries that submitted data for the most eligible professionals in 2011; this reflects both the PQRS and the eRx programs.¹³ Some registries are more specific to a certain specialty and, therefore, might not have a high volume of eligible professionals to report measures via their registry.

Table 10. Registries that Submitted Data on Behalf of the Most Eligible Professionals for the Physician Quality Reporting System or the eRx Incentive Program (2011)

Registry Name	Eligible Professionals Submitted by Registry
Epic Systems Corporation	6,165
DocSite	5,540
NextGen_Registry	4,851
Outcome(TM) PQRI Registry	3,706
GE Healthcare	3,581
Allscripts	2,985
Central Utah Informatics	2,774
Wisconsin Collaborative for Healthcare Quality	2,667
CECity	2,452
MDinteractive	2,226

Challenges to Participation and Satisfactory Reporting

The main challenges to satisfactory reporting in the Physician Quality Reporting System included: (1) failure to identify eligible patients or claims, (2) failure to submit QDCs for at least 50 percent of eligible instances (for claims reporting), and (3) QDC submission errors. For example, QDC submission errors encompass submitting a QDC on a claim that did not have a qualifying diagnosis or the appropriate patient age, or submitting an incorrect Healthcare Common Procedure Coding System (HCPCS) code. Eligible professionals who submitted data for fewer than three claims-based individual measures also had to pass the MAV process to confirm they were eligible for fewer than three measures. Almost one-third of eligible professionals (31 percent) submitting claims data were subject to MAV in 2011.¹⁴ In 2011, roughly six percent of those eligible professionals subject to the MAV process were not incentive eligible, which was only about two percent of eligible professionals who participated.

¹³ A complete listing of qualified registries available for the 2011 Physician Quality Reporting System can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/2011-Physician-Quality-Reporting-System-Items/2011_Qualified_Registries_Posting_2pdf.html

¹⁴ More information on the MAV process is available on the Physician Quality Reporting System website under the Analysis and Payment page: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html>

CMS posts the rates of QDC errors on the Physician Quality Reporting System website.¹⁵ Overall, 64,643,162 QDCs were submitted in 2011, of which about 12 percent were invalid (data not shown). These errors occurred when a QDC was submitted on a claim that did not have required information (e.g., diagnosis, procedure, gender) for that measure. An invalid QDC could occur, for example, if an eligible professional submits a QDC on a claim that lacks the necessary combination of diagnosis and procedure codes to identify the measure denominator. Because ineligible claims are not included in the measure denominator, QDC errors do not adversely affect an eligible professional's reporting rate.¹⁶ However, proactive monitoring and reporting of QDC errors can provide eligible professionals with information on the most common errors in reporting, which they can use to improve.

The most common QDC error was where the eligible professional reported a QDC on a claim that did not also have the required denominator eligible procedure code (HCPCS or CPT). Among 64,643,162 QDC submissions for all measures in 2011, 12 percent were invalid: 11 percent had an incorrect procedure code and/or an incorrect diagnosis code, two percent had an incorrect age and/or gender, and less than one-half of one percent were reported on instances with a missing procedure code.¹⁷

Though most measures reported had low rates of QDC errors, some measures reported had relatively high QDC error rates. For example, 73 percent of QDCs reported for measure #122 (Chronic Kidney Disease (CKD): Blood Pressure Management) had a mismatch between the QDC and the required diagnosis on the claim. Appendix Tables A14 through A16 highlight measures with high rates (greater than 20 percent) of specific QDC errors. It is recommended that eligible professionals double check the measure specifications to ensure accurate submission, especially if they are submitting measures with higher rates of submission errors.

Some Physician Quality Reporting System participants who used a registry experienced submission problems. For example, almost 20 percent of registries submitted incorrect reporting rates based on the submitted numerators and denominators. About seven percent of registries reported an invalid measure (e.g., a retired measure). About five percent of eligible professionals who submitted data through registries had a TIN/NPI combination that did not have any Part B MPFS allowed charges to receive an incentive payment, which could be due to an incorrect TIN/NPI combination. About two percent of eligible professionals submitting via registries were adversely affected by submission of individual measures with a zero percent performance rate (or 100 percent for inverse measures); measures with zero percent performance rate (100 percent performance rate for inverse measures) are not counted for satisfactory reporting; therefore, these eligible professionals were not incentive eligible. Finally, among registry measure group

¹⁵ For 2011, see the Physician Quality Reporting System website on the Analysis and Payment page. For prior years, see the Physician Quality Reporting System website and refer to the specific program year page (<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/>).

¹⁶ The reporting rate is the number of instances an eligible professional reported (e.g., a valid QDC) divided by the number of eligible instances.

¹⁷ More detail on the frequency of specific QDC errors can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/4th_Qtr_2011_Phy_Quality_Reptg_QDC_Error_Rpt_by_Measure_051412.pdf

reporters, roughly, one out of four had an eligible professional missing at least one measure within the measures group.

Participation by Specialty

Many measures in the Physician Quality Reporting System apply to emergency medicine and primary care, providing numerous opportunities for eligible professionals in these specialties to report on their Medicare patients.¹⁸ As shown in Table 11, of eligible professionals who participated through claims-based individual measures reporting option, emergency physicians had the largest representation among all specialties and also had a high rate of participation (67 percent). Hospital-based practices most likely have processes in place to capture clinical data accurately, allowing quicker uptake of reporting quality measure data. Eligible professionals in the fields of internal medicine and family practice also had a very large number of professionals who participated in the 2011 program; however, these specialties had lower than average participation rates. Appendix Table A7 shows eligibility and participation rates by specialty across all reporting options from 2008 to 2011. Participation rates by specialty and submission option for 2008 through 2011 can be found in Appendix Tables A8 through A11.

Table 11. Specialties with the Largest Number of Eligible Professionals Participating in the Physician Quality Reporting System through the Claims Individual Measures Reporting Option (2011)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Emergency Medicine	50,984	33,976	66.6%
Anesthesiology	42,936	23,070	53.7%
Nurse Anesthetist	44,104	17,130	38.8%
Internal Medicine	96,445	17,110	17.7%
Radiologist	37,474	17,012	45.4%
Family Practice	94,732	16,944	17.9%
Physician Assistant	46,784	11,093	23.7%
Optometry	32,404	8,811	27.2%
Other Eligible Professional	43,735	8,307	19.0%
Nurse Practitioner	56,593	8,115	14.3%

Note for Table 11: Results exclude GPRO.

The specialties with the largest number of eligible professionals who submitted data through the claims measures groups option are listed in Table 12. Internal medicine and family practitioners had the highest number of submissions of claims-based measures groups. Cardiologists had a large number submitting this data given that there are only two measures groups on which they could report.

¹⁸ In this section, “specialty” was determined based on the primary specialty that was listed for the NPI in the National Provider and Plan Enumeration System (NPPES); please see the Appendix for details.

Table 12. Specialties with the Largest Number of Eligible Professionals Participating in the Physician Quality Reporting System through the Claims Measures Groups Reporting Option (2011)

Specialty	Eligible Professionals who Participated
Internal Medicine	966
Family Practice	826
Cardiology	635
Orthopaedic Surgery	349
Other Eligible Professional	201
Rheumatology	183
Nurse Practitioner	183
Physical/Occupational Therapy	179
General Surgery	125
Physician Assistant	121

Note for Table 12: Results exclude GPRO.

Participation through registries was most frequent among eligible professionals who were family practitioners, internists, and cardiologists (Table 13).

Table 13. Specialties with the Largest Number of Eligible Professionals Participating in the Physician Quality Reporting System through the Registry Reporting Option (2011)

Specialty	Eligible	Participated	Percent of Eligible
Family Practice	94,732	11,420	12.1%
Internal Medicine	96,445	11,278	11.7%
Cardiology	24,089	4,951	20.6%
Nurse Practitioner	56,593	3,492	6.2%
Physician Assistant	46,784	2,410	5.2%
Other Eligible Professional	43,735	2,118	4.8%
Dermatology	10,466	1,850	17.7%
Obstetrics/Gynecology	30,627	1,826	6.0%
Nephrology	8,351	1,688	20.2%
Radiologist	37,474	1,540	4.1%

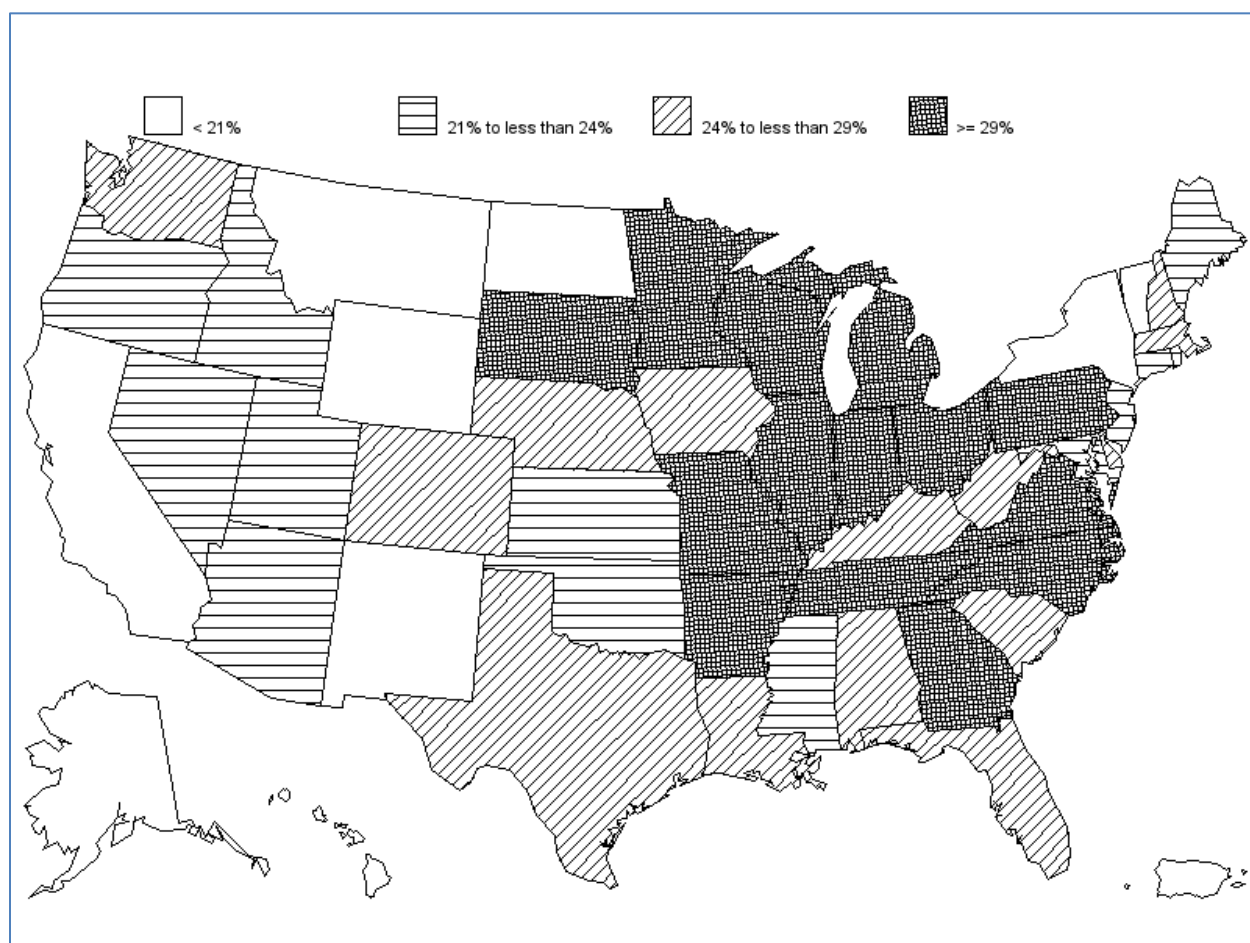
Note for Table 13: Results exclude GPRO.

Among eligible professionals encompassed in practices participating in the Physician Quality Reporting System through the GPRO (N=40,193), the most common eligible professional specialties were internists, family practitioners, nurse practitioners, physician assistants, and radiologists (representing 12 percent, eight percent, seven percent, six percent, and five percent of all eligible professionals encompassed within practices participating through the GPRO [data not shown]).

Geographic Variation in Participation

Figure 11 demonstrates the geographic variation in participation rates for the 2011 Physician Quality Reporting System.¹⁹ As in 2010, participation rates were highest in Wisconsin (38 percent) and North Carolina (37 percent). Participation was lowest (12 percent or lower) in Alaska, Puerto Rico, Virgin Islands, and Vermont. Detailed state-by-state participation results are available in Appendix Table A12. Participation was generally highest in states in the Southeast and Midwest.

Figure 11. Geographic Distribution of Eligible Professionals Participating in the Physician Quality Reporting System (2011)



Note for Figure 11: Results included all individual participation mechanisms (i.e., claims, registry, and EHR).

¹⁹ State was identified by the eligible professional in the National Plan and Provider Enumeration System (NPPES). Please see Appendix for details.

Participation by Measure

Many measures in the Physician Quality Reporting System were selected because they were applicable to a wide range of eligible professionals and Medicare beneficiaries. The measures applicable to the highest number of eligible professionals were those related to use of Health Information Technology (HIT), preventive care, and documentation of medications (Table 14).

Table 14. Individual Measures Reportable by the Largest Number of Eligible Professionals for the Physician Quality Reporting System (2011)

Measure Number	Measure Description	Eligible Professionals
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	781,820
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	722,617
130	Documentation of Current Medications in the Medical Record	710,120
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	682,002
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	675,446
47	Advance Care Plan	654,277
154	Falls: Risk Assessment	622,542
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	590,388
110	Preventive Care and Screening: Influenza Immunization for Patients \geq 50 Years Old	587,537
113	Preventive Care and Screening: Colorectal Cancer Screening	569,384

Note for Table 14: Results include the claims, registry, and EHR mechanisms; excludes results for the GPRO.

Table 15 lists measures reported by the largest number of eligible professionals. Although a large number of eligible professionals reported these measures, several measures were submitted by ten percent or fewer of those to which the measure was applicable, notably measure #124 (Adoption/Use of EHR), Measure #130 (Documentation of Current Medications in the Medical Record), and measure #226 (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention). Although measure #124 was only reported by nine percent of eligible professionals, this measure may only be reported by those eligible professionals who have a certified EHR system as described in the measure. Appendix Table A13 displays the percentage of eligible professionals who reported each measure and the average reporting rate (total instances reported for a measure divided by total eligible instances for the measure) for each measure reported through claims.

Table 15. Measures Reported by the Largest Numbers of Eligible Professionals Under the Physician Quality Reporting System (2011)

Measure Number	Measure Description	Participated	Percent of Eligible
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	70,961	9.1%
130	Documentation of Current Medications in the Medical Record	43,775	6.2%
54	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	42,918	59.5%
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	41,745	20.1%
30	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics	40,833	49.0%
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	38,357	5.6%
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status	37,778	18.2%
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	37,356	11.2%
56	Community-Acquired Pneumonia (CAP): Vital Signs	37,321	18.0%
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	36,001	10.8%

Note for Table 15: Results included claims, registry, and EHR mechanisms; excludes results for the GPRO.

Table 16 presents information on the top five measures submitted by each specialty, identified by measure number. Overall, among eligible professionals with an MD/DO, the top five measures reported were: #124 (Health Information Technology [HIT]: Adoption/Use of Electronic Health Records [EHR]); #1 (Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus); #130 (Documentation of Current Medications in the Medical Record); #3 (Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus); and #226 (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention).

Table 16. The Five Most Frequently Reported Individual Measures, by Specialty for the Physician Quality Reporting System (2011)

Specialty	#1 (Top)	#2	#3	#4	#5
MD/DO	124	1	130	3	226
Allergy/Immunology	124	110	226	130	111
Anesthesiology	30	193	76	124	130
Cardiology	6	124	226	130	204
Colon/Rectal Surgery	23	124	20	22	130
Critical Care	226	124	111	51	76
Dermatology	137	224	138	124	130
Emergency Medicine	54	57	55	56	58
Endocrinology	1	3	2	124	130
Family Practice	1	3	2	124	111
Gastroenterology	124	113	130	226	185
General Practice	124	3	57	1	54
General Surgery	124	21	23	20	22
Geriatrics	1	3	124	2	110
Hand Surgery	124	130	226	21	23
Infectious Disease	124	110	130	111	226
Internal Medicine	1	3	2	124	111
Interventional Radiologist	145	195	10	76	147
Nephrology	124	121	122	130	123
Neurology	124	130	226	31	32
Neurosurgery	21	124	22	20	23
Nuclear Medicine	147	124	6	145	195
Obstetrics/Gynecology	124	112	130	226	39
Oncology/Hematology	124	69	70	72	71
Ophthalmology	14	12	117	18	140
Oral/Maxillofacial Surgery	226	124	130	110	111
Orthopaedic Surgery	21	23	124	22	20
Other MD/DO	32	47	6	36	31
Otolaryngology	124	130	226	91	92
Pathology	99	100	124	226	110
Pediatrics	124	130	226	1	3
Physical Medicine	124	130	226	111	110
Plastic Surgery	124	226	130	20	21
Psychiatry	124	107	9	106	226
Pulmonary Disease	124	226	51	111	110
Radiation Oncology	105	104	156	194	102
Radiologist	145	10	195	146	147
Rheumatology	124	108	41	39	130

Specialty	#1 (Top)	#2	#3	#4	#5
Thoracic/Cardiac Surgery	43	45	44	21	124
Urology	48	124	50	49	226
Vascular Surgery	21	124	20	22	158
Other Eligible Professionals	124	30	130	193	226
Agencies/Hospitals/Nursing and Treatment Facilities	54	124	32	56	57
Audiologist	124	130	190	110	111
Certified Nurse Midwives	124	130	226	112	128
Chiropractor	131	182	124	130	226
Clinical Nurse Specialists	124	130	1	2	226
Counselor/Psychologist	124	134	107	106	9
Dentist	124	130	226	128	201
Dietitian/Nutritionist	2	1	3	124	128
Nurse Anesthetist	30	193	76	20	145
Nurse Practitioner	124	1	3	2	130
Optometry	14	12	117	140	18
Other Eligible Professional	124	130	226	54	57
Physical/Occupational Therapy	131	154	130	155	128
Physician Assistant	54	57	58	56	124
Podiatrist	126	127	163	124	130
Registered Nurse	30	193	124	1	2
Social Worker	124	107	106	134	9
Unknown/Missing	124	30	226	111	1
Total	124	130	30	226	1

Note for Table 16: Please refer to the Appendix Table A1 for measure descriptions; results included claims, registry, and EHR mechanisms and excluded GPRO. Results are presented at the Individual NPI level. ORDI participants have been removed from these results.

D. Incentive Eligibility

To qualify for an incentive under the Physician Quality Reporting System, eligible professionals must meet the criteria for satisfactory reporting applicable to the submission method and reporting period. An individual eligible professional was eligible for an incentive under the 2011 Physician Quality Reporting System if the eligible professional met the criteria applicable for at least one individual reporting option. The two basic criteria were:

- Percentage Method:
 - 50 percent of patients, individual measures option: An eligible professional could report at least 50 percent of eligible instances for at least three measures; this criterion applied to the individual measures option for the claims mechanism only. An eligible professional could qualify for an incentive by reporting at least

- 50 percent of eligible instances on one or two measures (i.e. less than three) if the MAV process was passed; the MAV process checked to ensure it was acceptable for an eligible professional to report less than three measures. Eligible professionals could report using this option for a 12-month (January 1 through December 31, 2011) or a 6-month (July 1 – December 31) period.
- 80 percent of patients, individual measures option: An eligible professional could report at least 80 percent of eligible instances for at least three measures; this criterion applied to the individual measures option for the registry and EHR reporting mechanisms. Eligible professionals could report using this option for a 12-month period (January 1 through December 31, 2011); in addition, eligible professionals who used the registry reporting mechanism could also choose to report on a 6-month (July 1 through December 31, 2011) period.
 - 50 percent of patients, measures groups option: An eligible professional could report all measures for at least one measures group among the 10 available for claims reporting provided they reported for at least 50 percent of all applicable Medicare Part B FFS patients. They could choose to report for a 12-month period (January 1 through December 31, 2011) for a minimum of 15 patients; they could also choose to report for a 6-month period (July 1 through December 31, 2011) for a minimum of eight patients.
 - 80 percent of patients, measures groups option: An eligible professional could report all applicable measures for at least one measures group among the 14 available for registry reporting provided they reported for at least 80 percent of applicable Medicare Part B FFS patients. They could choose to report for a 12-month period (January 1 through December 31, 2011) for a minimum of 15 patients; they could also choose to report for a 6-month period (July 1 through December 31, 2011) for a minimum of eight patients.
 - 30 Patient Method: An eligible professional could report at least one measures group for at least 30 patients; this criterion applied to the claims and registry mechanisms. The option required all Medicare Part B FFS patients for both claims- and registry-reporting. Participants using the 30-patient reporting criterion for the claims or registry reporting mechanisms were required to use a 12-month reporting period (January 1, 2011 through December 31, 2011).

In addition the incentive eligibility criteria listed above, measures submitted via a registry or EHR with a performance rate of zero percent were not used to calculate incentive eligibility; inverse measures are an exception since a zero percent performance rate indicates the desired performance on these measures.

A practice that participated in the GPRO I for the 2011 Physician Quality Reporting System was incentive eligible if the group practice met the applicable reporting criteria for satisfactory reporting. Under GPRO I, a practice was required to report on the first 411 preselected Medicare patients for each GPRO I measure or on all eligible patients for a measure where fewer than 411 were available. GPRO II satisfactory reporting requirements varied by group practice size, as described in the Data and Methods section of the Appendix to this report.

Eligible professionals meeting the requirements for satisfactory reporting qualified for an incentive payment equal to one percent of CMS's estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional or group practice during the applicable reporting period in 2011. Additional detail about incentive eligibility is described in the Appendix.

Incentive Eligibility by Reporting Approach

More than eight out of ten eligible professionals who participated in the 2011 Physician Quality Reporting System qualified for an incentive (83 percent), higher than the 2010 rate (72 percent) (Appendix Table A17). In the 2011 program, the percentage of eligible professionals who qualified for an incentive varied widely by reporting option. Figure 7 shows the percentage of participants qualifying for an incentive payment was highest among those using registry (88 percent for registry individual measures and 92 percent for registry measures groups) and EHR reporting (90 percent) and lowest among those using the claims-based mechanism (77 percent for individual claims and only 64 percent for claims measures groups). All 54 practices that participated under the GPRO I option qualified for an incentive payment (not shown).

Incentive Eligibility by Specialty

The specialties with the most eligible professionals who qualified for an incentive follow the same patterns as participation. Across all reporting options, emergency medicine, family practice, and internal medicine had the largest number of eligible professionals who earned an incentive (Appendix Table A2). Appendix Tables A18 through A21 present the percentage of eligible professionals from each specialty who qualified for an incentive by program year for each reporting method. Tables 17 through 19 display the specialties with the most eligible professionals who earned an incentive for each reporting approach.

Among the specialties with the most eligible professionals who qualified for an incentive through the claims-based individual option, emergency medicine and physician assistants also had relatively high rates of incentive eligibility (Table 17).

Table 17. Top 10 Specialties Earning a Physician Quality Reporting System Incentive - Claims-Based Individual Measures Reporting Option (2011)

Specialty	Eligible Professionals who Participated	Eligible Professionals who Qualified for an Incentive	Percent who Qualified for an Incentive
Emergency Medicine	33,976	32,260	94.9%
Anesthesiology	23,070	19,352	83.9%
Nurse Anesthetist	17,130	14,006	81.8%
Radiologist	17,012	13,088	76.9%
Family Practice	16,944	11,424	67.4%
Internal Medicine	17,110	11,341	66.3%
Physician Assistant	11,093	9,569	86.3%
Nurse Practitioner	8,115	6,314	77.8%
Other Eligible Professional	8,307	6,308	75.9%
Ophthalmology	8,087	6,109	75.5%

As seen in Table 18, numbers and incentive eligibility rates among some specialties that participated in the claims-based measures groups reporting options were lower than other reporting options; however, cardiologists and rheumatologists had relatively high proportions of eligible professionals who qualified for an incentive.

Table 18. Top 10 Specialties Earning a Physician Quality Reporting System Incentive - Claims-Based Measures Groups Reporting Option (2011)

Specialty	Eligible Professionals who Participated	Eligible Professionals Who Qualified for an Incentive	Percent Who Qualified for an Incentive
Internal Medicine	966	687	71.1%
Cardiology	635	504	79.4%
Family Practice	826	487	59.0%
Orthopaedic Surgery	349	247	70.8%
Rheumatology	183	140	76.5%
Other Eligible Professional	201	125	62.2%
Nurse Practitioner	183	108	59.0%
Physician Assistant	121	59	48.8%
Physical/Occupational Therapy	179	50	27.9%
Endocrinology	66	50	75.8%

The incentive eligibility rates for eligible professionals who used registry-based reporting were quite high among the top specialties that participated. Although, other eligible professionals' incentive eligibility rates were lower than rates observed for MD/DO specialties (Table 19).

Table 19. Top 10 Specialties Earning a Physician Quality Reporting System Incentive – Reporting via Registries (2011)

Specialty	Eligible Professionals who Participated	Eligible Professionals Who Qualified for an Incentive	Percent Who Qualified for an Incentive
Family Practice	11,420	10,727	93.9%
Internal Medicine	11,278	10,061	89.2%
Cardiology	4,951	4,686	94.7%
Nurse Practitioner	3,492	2,877	82.4%
Physician Assistant	2,410	2,011	83.4%
Other Eligible Professional	2,118	1,866	88.1%
Dermatology	1,850	1,754	94.8%
Obstetrics/Gynecology	1,826	1,602	87.7%
Nephrology	1,688	1,561	92.5%
Radiologist	1,540	1,416	92.0%

E. Clinical Performance Rates

Although the Physician Quality Reporting System focuses on reporting of quality data by eligible professionals, clinical performance rates that use quality data submitted through the program can also be used to make inferences about the quality of care provided to Medicare beneficiaries.

Eligible professionals reported data on recommended quality actions that were performed, not performed, or did not apply (i.e., exclusions) on eligible instances; this information is used in this report to describe eligible professionals' clinical performance on measures. However, multiple factors should be considered when interpreting trends in the performance information. For example, there have been many changes within the Physician Quality Reporting System across program years. As described above, the participation options have been changed and refined. Individual measures were added, removed, or augmented. Moreover, the eligible professionals who participated each year change. Consequently, changes in performance rates could be genuine, represent changes in how the information was obtained, or represent changes in the group of eligible professionals submitting the data. As a result, it is unclear the extent that any observed changes in performance on the measures were real or artifacts of the aforementioned changes.

Nonetheless, this section of the report aims to describe clinical performance rates and trends.²⁰ The Appendix Tables A22 and A23 provide reporting and performance information across program years. Changes in reporting and performance rates should be interpreted with caution because they include modifications to the Physician Quality Reporting System, such as new reporting options and participation methods and growth in the number of participants. Appendix

²⁰ Please see the Appendix for further description of performance rate calculations.

Tables A24 to A27 display performance information among eligible professionals reporting the same individual measure for multiple program years. Appendix Table A24 describes how the number of eligible professionals who consistently reported measures across successive program years has increased. Appendix Tables A25 to A27 provide total counts for eligible professionals who have reported a measure for each of the past four, three, or two years, respectively.

Tables 20 and 21 display the measures with the largest percentage point decline and improvement in reporting between 2008 and 2011, among eligible professionals who reported the same measure for all four years. While this information attempts to account for changes in who participated, it does not account for other changes. For example, trends in reporting mechanisms—such as a growth in registry reporting or a measure changing to/from registry reporting only—could influence performance rates upward. Other examples of changes to measures include the addition of new exclusions or changes in thresholds used to define clinical control of a condition. Registries, in some cases, incorporate processes that support eligible professionals' selection of appropriate measures, edits that help to ensure that measures are submitted accurately, and reminders that help providers meet the performance criteria of the measures.

Table 20. Individual Measures Reported with the Largest Percentage Point Decrease in Clinical Performance Rate for the Physician Quality Reporting System (2008 and 2011)

Measure Number	Measure Description	2008 Performance Rate	2011 Performance Rate	Percentage Point Change 2008-2011
40	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	70.9%	57.4%	-13.5%
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	96.3%	87.0%	-9.3%
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	10.9%	16.7%	-5.8%
24	Osteoporosis: Communication with the Physician Managing On-going Care Post- Fracture of Hip, Spine, or Distal Radius for Men and Women Aged 50 Years and Older	61.2%	55.5%	-5.7%
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	78.3%	72.8%	-5.5%

Note for Table 20: Results included the claims, registry, and EHR reporting mechanisms. Results were restricted to a group of eligible professionals who reported the same measure from 2008 to 2011. Measure #1 was an inverse measure where a lower performance rate indicated better performance. This table includes measure performance regardless of whether eligible professionals reporting the measure met the satisfactory reporting requirement.

Table 21. Individual Measures Reported with the Largest Percentage Point Increase in Clinical Performance Rate for the Physician Quality Reporting System (2008 and 2011)

Measure Number	Measure Description	2008 Performance Rate	2011 Performance Rate	Percentage Point Change 2008-2011
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care	50.9%	93.9%	43.0%
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	63.4%	91.8%	28.5%
72	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients	81.1%	99.2%	18.1%
71	Breast Cancer: Hormonal Therapy for Stage IC-IIIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer	81.9%	99.4%	17.6%
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	57.0%	73.7%	16.8%

Note for Table 21: Results included the claims, registry, and EHR reporting mechanisms. Results were restricted to a group of eligible professionals who reported the same measure from 2008 to 2011. This table includes measure performance regardless of whether eligible professionals who reported the measure met the satisfactory reporting requirement.

For some measures, improvement in measure performance over time was limited by measure performance that ‘topped out.’ In other words, if performance is at or near 100 percent, the ability to improve performance is limited. Table 22 displays the measures with the highest mean clinical performance rates in 2011.

Table 22. Individual Measures Reported with the Highest Mean Clinical Performance Rates for the Physician Quality Reporting System (2011)

Measure Number	Measure Description	Mean Performance Rate	Number of Eligible Professionals Submitting
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	99.0%	1,229
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	98.9%	70,961
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy	98.6%	760
146	Radiology: Inappropriate Use of “Probably Benign” Assessment Category in Mammography Screening*	1.5%	9,335

Measure Number	Measure Description	Mean Performance Rate	Number of Eligible Professionals Submitting
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	98.3%	1,464
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	98.0%	4,450
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	97.7%	1,147
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status	97.7%	37,778

*Note for Table 22: Results included the claims, registry, and EHR reporting mechanisms. * Measure #146 was an inverse measure where a lower performance rate indicated better performance.*

Some measures show particularly high rates of performance across all eligible professionals. Table 23 displays measures where at least 90 percent of the eligible professionals who reported a measure achieved performance at or above 90 percent in 2011. Appendix Table A28 is similar and displays the percent of eligible professionals who reported a measure and had a performance rate at or above 90 percent by individual measure.

Table 23. Individual Measures where at least 90 Percent of Eligible Professionals who Participated had at least a 90 Percent Performance Rate for the Physician Quality Reporting System (2011)

Measure Number	Measure Description	Percent of Eligible Professionals with At Least 90% Performance Rate
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	98.5%
146	Radiology: Inappropriate Use of “Probably Benign” Assessment Category in Mammography Screening	98.4%
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	96.9%
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	96.3%
66	Appropriate Testing for Children with Pharyngitis	95.8%
192	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	95.6%

Measure Number	Measure Description	Percent of Eligible Professionals with At Least 90% Performance Rate
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status	94.2%
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy	94.1%
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	93.4%
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	93.1%
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	92.7%
137	Melanoma: Continuity of Care – Recall System	91.7%
56	Community-Acquired Pneumonia (CAP): Vital Signs	91.6%
131	Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up	91.6%
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	91.0%
55	12-Lead Electrocardiogram (ECG) Performed for Syncope	90.7%
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	90.6%
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	90.4%
181	Elder Maltreatment Screen and Follow-Up Plan	90.2%
238	Drugs to be Avoided in the Elderly	90.0%

Note for Table 23: Results included the claims, registry, and EHR reporting mechanisms. Measure #124 was not 100% due to incorrect data reported via registry (i.e., the only valid option for reporting is that the performance action was met). Measures #146, #192, and #238 were inverse measures where a lower performance rate indicated better performance; for these measures <= 10% was used (i.e., instead of >= 90%). This table includes measure performance for eligible professionals regardless of whether the eligible professional met the satisfactory reporting requirement.

GPRO Performance

Group practices reporting under the GPRO I reported aggregate results for 26 measures covering coronary artery disease, diabetes mellitus, heart failure, hypertension, and preventive care. Appendix Table A29 summarizes quality measure reporting and performance of the practices participating in the 2011 program through the GPRO I option. Practices reported measures for, on average, over 400 eligible assigned beneficiaries; a few CAD and heart failure measures were reported less often. The measures reported for the most eligible assigned beneficiaries, on average, were for weight measurement among heart failure patients and blood pressure management for those with hypertension. Performance rates for the measures ranged from a low of 53 percent for the “LDL-C control among diabetes patients” quality measure to a high of 92 percent for the “beta blocker therapy for left ventricular systolic dysfunction in heart failure patients” quality measure. In general, performance on measures for conditions such as CAD and heart failure was higher (71 percent to 92 percent) than performance on preventive measures such as mammography, colorectal cancer screening, influenza immunization, and pneumonia vaccination (60 percent to 66 percent).

IV. ELECTRONIC PRESCRIBING (ERX) INCENTIVE PROGRAM

A. Background

Program Description

Section 132 of the MIPPA authorized a new and separate incentive program—the Electronic Prescribing Incentive Program (eRx)—for eligible professionals who are successful electronic prescribers, as defined by MIPPA. The incentive program began on January 1, 2009.

Under the eRx Incentive Program, eligible professionals report data on the electronic prescribing quality measure to describe their use of a qualified eRx system during an eligible visit with a Medicare beneficiary. As defined under the electronic prescribing quality measure, a qualified eRx system is one that is capable of all of the following:²¹

- 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.²²
- Provide information related to lower cost and therapeutically appropriate alternatives (if any).
- Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available).

In addition, the system must employ, for the capabilities listed, the e-prescribing standards adopted by the Secretary for Part D. Individual eligible professionals did not need to participate in the Physician Quality Reporting System to participate in the eRx Incentive Program. To participate in the eRx Incentive Program, eligible professionals could have reported data on the eRx quality measure on eligible Medicare Part B claims indicating a qualified eRx system was used. Beginning in 2010, individual eligible professionals also could submit data through a qualified registry or a qualified EHR vendor to indicate use of a qualified eRx system. In addition, group practices were eligible to report data on the eRx quality measure under the GPRO (two options – GPRO I and GPRO II, using claims, registry, or EHR), if they self-nominated to report the eRx quality measure as a group and were approved to participate in the Physician Quality Reporting System. In 2011, the GPRO option for practices with 200 or more eligible professionals was referred to as GPRO I, and smaller group practices (from 2-199 eligible professionals) were also eligible to participate under the option referred to as GPRO II.

²¹ The eRx measure specification can be found at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive>

²² Alerts are written or acoustic signals to warn prescribers of possible undesirable or unsafe situations, including potentially inappropriate dose, route of administration, drug-drug interactions, allergy concerns, or warnings and cautions.

The GPRO II option in 2011 was divided into tiers depending on the number of eligible professionals within the practice: Tier 1 (2-10), Tier 2 (11-25), Tier 3 (26-50), Tier 4 (51-100), and Tier 5 (101-199).

To participate in the 2011 eRx Incentive Program under the claims submission method, eligible professionals reported a QDC, also known as a G-code, for the eRx quality measure on a Part B MPFS claim for an “eligible instance.” Eligible instances are instances when the measure was applicable, as determined based on the presence of a specific set of procedure codes on a claim.²³ In 2010 and 2011, there was one valid QDC for the eRx quality measure:

- **G8553:** At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.

In addition to reporting via claims, eligible professionals could report data on the eRx quality measure through a qualified registry or EHR vendor.

To earn the incentive payment for the 2011 eRx Incentive Program, an individual eligible professional had to meet two criteria:

1. **Be a Successful Electronic Prescriber.** Individual eligible professionals had to report the eRx measure for at least 25 visits (eligible instances) during the reporting period. For practices participating through the GPRO I option, the number of visits required was 2,500 during the reporting period. For the GPRO II option, the number of unique visits required during the reporting period varied by tier:
 - 2-10 NPIs = 75 eligible unique visits
 - 11-25 NPIs = 225 eligible unique visits
 - 26-50 NPIs = 475 eligible unique visits
 - 51-100 NPIs = 925 eligible unique visits
 - 101-199 NPIs = 1,875 eligible unique visits
2. **10 Percent Threshold Limitation.** During the reporting period, the allowed charges for Medicare Part B covered professional services furnished by the eligible professional for the codes that appear in the eRx quality measure denominator must be at least 10 percent of the total allowed Part B MPFS charges for all such covered professional services furnished by the eligible professional. The same requirement applied to group practices that participated through the GPRO under the eRx Incentive Program.

²³ 2011 denominator codes (CPT/HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, and G0109.

The 2011 eRx Incentive Program incentive was equal to one percent of total estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional during the reporting period.

Program Evolution

After expanding the eRx incentive program in 2010, CMS did not make any changes to the reporting requirements for the 2011 program for individual eligible professionals (see Table 24). For group practices, CMS added a new reporting option under the GPRO (GPRO II) that is available to practices with between 2 and 199 eligible professionals; previously, only practices with 200 or more eligible professionals could participate in the original GPRO (now known as GPRO I). In 2012, CMS adopted multiple reporting options under the GPRO based on large and small group practice sizes.

Beginning in 2012, section 1848(a)(5) of the Social Security Act requires CMS to apply a payment adjustment to eligible professionals who are not successful electronic prescribers under the eRx Incentive Program. For 2012, the payment adjustment is applied as a percent reduction to Medicare Part B covered professional services furnished between January 1 and December 31, 2012, for those eligible professionals who are not successful electronic prescribers during the 6-month reporting period (January 1 – June 30) of 2011, and who do not otherwise qualify for an exemption from the payment adjustment. Certain types of eligible professionals were not subject to the adjustment:

- Those that were not physicians (MD/DO, or podiatrist), nurse practitioners, or physician assistants as of September 12, 2011, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES).
- Those that did not have at least 100 eligible claims containing an encounter code in the measure denominator.
- Those that did not meet the 10 percent threshold limitation were not eligible for the adjustment.

To avoid the payment adjustment for 2012, individual eligible professionals who did not meet any of these automatic exclusion criteria had to report the G8553 code via claims for at least 10 denominator eligible eRx events for services provided during the six-month period January 1, 2011, through June 30, 2011. The reporting criteria (number of eligible unique visits based on group practice size) that needed to be satisfied to avoid the 2012 payment adjustment for practices reporting via GPRO are listed in the previous section.

Alternatively, eligible professionals and practices could avoid the payment adjustment if one of the following applied:²⁴

²⁴ See Final Rule for further details at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS1240932.html>

- Reporting a G-code G8644 (defined as not having prescribing privileges) at least one time on an eligible claim between January 1, 2011 and June 30, 2011.
- Requesting (by reporting the applicable G-code via claims by June 30, 2011) and being granted a significant hardship exemption for the following reasons:
 - G8642: The eligible professional practices in a rural area without sufficient high speed internet access.
 - G8643: The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing.
- Requesting (by November 8, 2011 through the CSP, or via mail for GPROs) and being granted a significant hardship exemption for the following reasons:
 - Eligible professionals (or GPROs with eligible professionals) registered to participate in the Medicare or Medicaid EHR Incentive Programs and adopt Certified EHR Technology.
 - Inability to electronically prescribe due to local, state, or federal law or regulation (e.g., controlled substances).
 - Limited prescribing activity.
 - Insufficient opportunities to report the electronic prescribing measure due to limitations of the measure's denominator.

Table 24 summarizes changes in the eRx Incentive Program rules from 2010 to 2012. The main changes over this period were the introduction of new options for reporting under the GPRO, a reduction in the applicable incentive percentage, and the introduction of the 2012 payment adjustment.

Table 24. Summary of eRx Incentive Program Requirements (2010 to 2012)

	2010	2011	2012
Applicable Percent*	2%	1%	1%
Reporting Mechanisms available to individual eligible professionals and group practices	Claims, Registry, EHR	Claims, Registry, EHR	Claims, Registry**, EHR**
Individual or GPRO	Individual Eligible Professionals, Group Practices of 200 or more EPs	Individual Eligible Professionals, Group Practices (GPRO I), Group Practices (GPRO II)	Individual Eligible Professionals, Small Group Practices, ** Large Group Practices **
Quality-Data Code(s)	G8553	G8553	G8553
Successful Electronic Prescriber Reporting Requirement for Individual Participation	At least 25 eligible events	At least 25 eligible events	At least 25 eligible events
Successful Electronic Prescriber Reporting Requirement for Group Practice Reporting Option (GPRO)	At least 2,500 eligible events	<u>GPRO I:</u> At least 2,500 eligible events <u>GPRO II:</u> requirement varied by number of eligible professionals per practice: 2 to 10 (75 events) 11 to 25 (225 events) 26 to 50 (475 events) 51 to 100 (925 events) 101 to 199 (1,875 events)	<u>Small Group Practices:</u> At least 625 eligible events <u>Large Group Practices:</u> At least 2,500 eligible events
10% Threshold Limitation	At least 10% of total Part B MPFS allowed charges for covered services for the codes to which the eRx measure applies	At least 10% of total Part B MPFS allowed charges for covered professional services for the codes to which the eRx measure applies	At least 10% of total Part B MPFS allowed charges for covered professional services for the codes to which the eRx measure applies
Payment Adjustment Applicable Percent	n/a	n/a	1%

* Applicable Percent is applied to total estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional during the reporting period. ** Only registries, EHR vendors, and group practices that qualified for the 2012 Physician Quality Reporting System were able to participate in the eRx Incentive Program.

B. Incentive Payments

In 2011, CMS paid \$285,049,103 in incentive payments to 174,189 eligible professionals (including individual participants who were incentive eligible and eligible professionals who are part of a group practice that was incentive eligible under the GPRO) and 43,132 practices (Table 5). The average incentive payment was \$1,912 per eligible professional and \$6,609 per practice (Table 25). The decrease in average incentive payments from 2010 to 2011 is partially attributable to the decrease in the applicable percent used to calculate the incentive payment from two percent to one percent.

Table 25. eRx Incentive Payments (2009 to 2011)

	2009	2010	2011
Average Incentive Payment per Eligible Professional	\$3,061	\$3,836	\$1,912
Average Incentive Payment per Practice	\$14,501	\$14,476	\$6,609
Total Incentive Amounts	\$148,007,816	\$270,895,540	\$285,049,103

Note for Table 25: Results for eligible professionals who reported via the claims, registry and EHR reporting mechanisms. Results for practices included reporting under the GPRO via claims, registry, and EHR.

Appendix Table A31 presents the distribution of incentive payments by specialty in 2011. The majority of 2011 incentive payments were paid to the top participating specialties—internal medicine, cardiology, ophthalmology, and family practice. Appendix Table A32 shows the average potential incentive by specialty (based on one percent of estimated total Part B MPFS allowed charges for covered professional services furnished by eligible professionals during the reporting period) and the participation rate. Some specialties with relatively high potential incentives but relatively low participation included specialties with more difficulty meeting the 10 percent threshold limitation (e.g., radiation oncology, interventional radiology, and radiology).

C. Participation

How to Participate

With one measure and one reporting period (January 1 through December 31, 2011), for the eRx incentive, participating in the eRx Incentive Program was relatively straightforward. Individual eligible professionals did not have to enroll or file any intent to participate in the eRx Incentive Program. In 2011, eligible professionals or a group practice that participated under the eRx Incentive Program GPRO could use the claims-based mechanism to report the eRx quality measure (one QDC indicating at least one prescription was generated using a qualified eRx system). Alternatively, eligible professionals and group practices could report the quality measure under the eRx Incentive Program through qualified registries or EHR vendors. To be a successful electronic prescriber, eligible professionals had to report the eRx quality measure in at least 25 eligible instances via one reporting mechanism (i.e., claims, registry or EHR) during the reporting period. A practice participating under the GPRO I option had to report the eRx quality measure in at least 2,500 eligible instances. Smaller practices (between two and 199 eligible

professionals) participating under the GPRO II had to report the eRx quality measure in varying numbers of instances, depending on the size of the group practice (see Table 24).

Participation Findings

Overall, 748,224 eligible professionals could have participated in the eRx Incentive Program in 2011 compared to 696,663 in 2010. In addition, there were 84 CMS-qualified group practices that indicated their intent to participate through GPRO I or II in 2011; however, ten of these practices did not participate (Table 5). In the first half of 2012, there were 636,433 professionals eligible for the eRx Incentive Program, 62 large practices (100 or more NPIs) and eight small practices (25 to 99 NPIs).

Eligible professionals who chose to participate in the 2011 eRx Incentive Program using the registry or EHR-based reporting options contacted the CMS-qualified registries or EHR vendors listed in the posted CMS qualified lists.²⁵ In 2011, there were 63 qualified registries, 45 of which submitted eRx quality measure information. There were 14 EHR vendors qualified by CMS to submit EHR data; three EHR vendors' products were used to submit data.

Overall, 282,382 eligible professionals (38 percent of those eligible) participated in the 2011 eRx Incentive Program (Figure 5), which was a 116 percent increase from total participants in 2010. Most of the increase in participants was through claims-based reporting.

In addition, 43 practices (out of 47 qualified by CMS to participate), encompassing 34,943 eligible professionals, participated in the eRx Incentive Program under the GPRO I, while 31 practices (out of 37 qualified by CMS to participate), encompassing 674 eligible professional professionals, participated in the eRx Incentive Program under the GPRO II.

Although results for 2012 were incomplete at the time this report was prepared, by June 2012 242,240 eligible professionals submitted data for the eRx measure through claims (Figure 5). In addition, at the time this report was prepared, under the GPRO there were 62 qualified large groups submitting data on the eRx quality measure (practices with 100 or more NPIs) and eight qualified small group practices submitting data (practices with 25 to 99 NPIs) in 2012. Results for registry and EHR submissions were not yet available at the time this document was created.

In 2011, eligible professionals submitted a total of 18,483,252 eRx QDCs through claims, with an average of 73 QDCs submitted per eligible professional (not including GPROs; data not shown). Nearly all (96 percent) of these QDCs were correctly submitted. QDCs were rejected, for example, when an eligible professional used an incorrect procedure code (i.e., HCPCS/CPT code). Among registry reporters, registry data for 700 EPs showed counts of 25 or more eRx instances; however, claims data for these EPs showed less than 25 eligible instances.

MD/DO practitioners were more likely than other types of eligible professionals to participate in the eRx Incentive Program in 2011 (Table 26). Over two in five (41 percent) MD/DOs

²⁵ <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Alternative-Reporting-Mechanism.html>

participated while less than one quarter of eligible professionals (23 percent) in the “other eligible professionals” category participated.

Table 26. Number of Eligible Professionals Participating in the eRx Incentive Program by Specialty Category (2011)

Type of Eligible Professional	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
MD/DO	472,929	192,986	40.8%
Other Eligible Professionals	236,371	53,684	22.7%
Unknown/Missing	662	95	14.4%
Total (Unduplicated)	709,962	246,765	34.8%

Note for Table 26: Results included reporting via the claims, registry, and EHR mechanisms.

Certain specialties were more likely to participate in the 2011 eRx Incentive Program than others (Table 27). Family practice and internal medicine had the largest number of eligible and participating professionals. Specialties with particularly high rates of participation included cardiology (64 percent), rheumatology (62 percent), urology (61 percent), and ophthalmology (60 percent). Appendix Table A33 presents participation results for all specialties.

Table 27. Specialties with the Highest Participation in the eRx Incentive Program (2011)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Specialties with highest counts	--	--	--
Family Practice	86,432	42,102	48.7%
Internal Medicine	77,264	35,858	46.4%
Nurse Practitioner	49,550	16,746	33.8%
Cardiology	22,588	14,482	64.1%
Other Eligible Professional	31,751	11,587	36.5%
Specialties with highest rates	--	--	--
Cardiology	22,588	14,482	64.1%
Rheumatology	4,188	2,608	62.3%
Urology	9,116	5,560	61.0%
Ophthalmology	19,083	11,479	60.2%
Nephrology	7,552	4,355	57.7%

Note for Table 27: Results included reporting via the claims, registry, and EHR mechanisms.

Among the 35,617 eligible professionals within practices participating in the 2011 eRx Incentive Program under the GPRO I or II, the most common eligible professional specialties were internists, family practitioners, physician assistants, nurse practitioners, anesthesiologists, and radiologists (representing 13 percent, eight percent, seven percent, seven percent, five percent, and five percent, respectively, of all eligible professionals within practices participating in the eRx Incentive Program under the GPRO).

There was a strong correlation between the number of Medicare beneficiaries seen by an eligible professional and the likelihood of participating in the 2011 eRx Incentive Program (Appendix Table A35). Eligible professionals with more than 200 eligible beneficiaries with an eligible eRx instance were nearly ten times more likely to participate than eligible professionals with fewer than 25 beneficiaries for whom to report data. This could indicate eligible professionals who would not meet the 10 percent threshold limitation were less likely to participate in the eRx Incentive Program.

Participation rates in the 2011 eRx Incentive Program varied by state. Figure 12 presents the distribution of participation rates across the country. Excluding territories, the participation rate in the 2011 eRx Incentive Program ranged from 20 percent in Alaska (330 eligible professionals) to approximately 45 percent in South Carolina (3,929 eligible professionals). States with the highest participation rates were concentrated in the South and the Midwest. The number of eligible professionals participating in the 2011 eRx Incentive Program ranged from 319 in Wyoming to 18,831 in California (Appendix Table A36). It should be noted that some state law limitations on electronic prescribing may affect eligible professionals from participating in the eRx Incentive Program.

Figure 12. Geographic Distribution of Eligible Professionals Participating in the eRx Incentive Program (2011)



Note for Figure 12: Results included reporting via the claims, registry, and EHR mechanisms.

D. Incentive Eligibility

To qualify for the 2011 incentive payment equal to one percent of estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional during the reporting period, an eligible professional or a group practice participating under the eRx GPRO must have been a successful electronic prescriber and their allowed charges for services identified in the eRx quality measure's denominator must have been at least ten percent of the eligible professional's total 2011 estimated Part B MPFS allowed charges (the 10% threshold limitation). To be a successful electronic prescriber in 2011, individual eligible professionals had to report the eRx quality measure for at least 25 eligible instances via one reporting mechanism (i.e., claims, registry, or EHR); instances could not be combined across multiple mechanisms. Practices participating under the GPRO I had to report the eRx quality measure for at least 2,500 eligible instances. Smaller practices (between two and 199 eligible professionals) participating under the GPRO II had to report the measure in varying levels of qualifying instances, depending on practice size (see Table 24).

In 2011, 174,189 eligible professionals (including eligible professionals within group practices that received an incentive through the GPRO) and 43,132 practices qualified for an incentive in the eRx Incentive Program (Table 5). These 174,189 eligible professionals equate to 62 percent of eligible professionals who participated. Of the 43 practices participating under the GPRO I, 40 qualified for incentives, totaling \$15,888,060. Under the GPRO II, 29 of the 31 qualifying practices earned incentives, totaling \$811,306 (Appendix Table A39).

Table 28 presents the specialties with the highest number of eligible professionals qualifying for an eRx incentive in 2011, as well as the specialties with the highest rates of incentive eligibility among those submitting data on the eRx quality measure. Family practice and internal medicine were among the specialties with the largest number of participants who were incentive eligible and who had relatively high rates of incentive eligibility.

The percent of participating eligible professionals who were eligible for an incentive varied widely across specialties (Appendix Table A34). Among specialties with at least 50 eligible professionals who participated, the rate of incentive eligibility ranged from less than 20 percent for three specialties (plastic surgery, general surgery, and vascular surgery) to over 70 percent for four specialties (urology, internal medicine, nuclear medicine, and rheumatology).

As seen in Appendix Table A35, incentive eligibility rates were highest among those using the registry reporting option (82 percent) compared with claims (55 percent). Incentive eligibility rates were also notably larger among practices with at least 200 beneficiary visits (71 percent) compared to those with 26 to 100 beneficiary visits (30 percent).

Table 28. Specialties with the Highest Incentive Eligibility for the eRx Incentive Program (2011)

Specialty	Eligible Professionals who Participated	Eligible Professionals who Qualified for an Incentive	Percent of Participating Eligible Professionals who Qualified for an Incentive
Specialties with highest counts	--	--	--
Family Practice	42,102	29,389	69.8%
Internal Medicine	35,858	25,549	71.3%
Cardiology	14,482	9,851	68.0%
Ophthalmology	11,479	7,939	69.2%
Nurse Practitioner	16,746	7,344	43.9%
Specialties with highest rates	--	--	--
Rheumatology	2,608	1,954	74.9%
Nuclear Medicine	77	55	71.4%
Internal Medicine	35,858	25,549	71.3%
Urology	5,560	3,907	70.3%
Family Practice	42,102	29,389	69.8%

Note for Table 28: Results included the claims, registry, and EHR reporting mechanisms. Certain types of professionals with low counts (i.e., chiropractors and nurse anesthetists) were not included in this table.

Though 174,189 eligible professionals qualified for incentives in the 2011 eRx Incentive Program, 176,298 eligible professionals were successful electronic prescribers in 2011. Of those eligible professionals, 2,109 failed to meet the 10 percent threshold for incentive eligibility (Appendix Table A37). Among eligible professionals with an MD/DO, the specialties with the highest rates of successful electronic prescribers who did not reach the 10 percent threshold (and with more than one eligible professional who failed to reach the threshold) included radiation oncology and thoracic/cardiac surgery. These specialties may provide relatively few of the procedures applicable to the eRx measure (e.g., evaluation and management visits) and therefore could not reach the 10 percent threshold for incentive eligibility.

E. eRx Payment Adjustment

For the 2012 eRx payment, eligible professionals who were not successful electronic prescribers under the eRx Incentive Program during the reporting period (the first half of 2011) and did not otherwise qualify for an exemption from the payment adjustment were subject to a one percent deduction to the MPFS for Medicare Part B services furnished between January 1 and December 31, 2012. In total, 135,931 eligible professionals (including GPRO) were subject to the 2012 payment adjustment.

Certain types of individually participating eligible professionals were not subject to the payment adjustment:

- Those that were not physicians (MD/DO, or podiatrist), nurse practitioners, or physician assistants as of September 12, 2011, based on primary taxonomy code in the National Plan and Provider Enumeration System.
- Those that did not have at least 100 eligible claims containing an encounter code in the measure denominator.
- Those that did not meet the 10% limitation threshold were not eligible for the adjustment.

Eligible professionals who did not meet any of the three criteria above could still avoid the payment adjustment if:

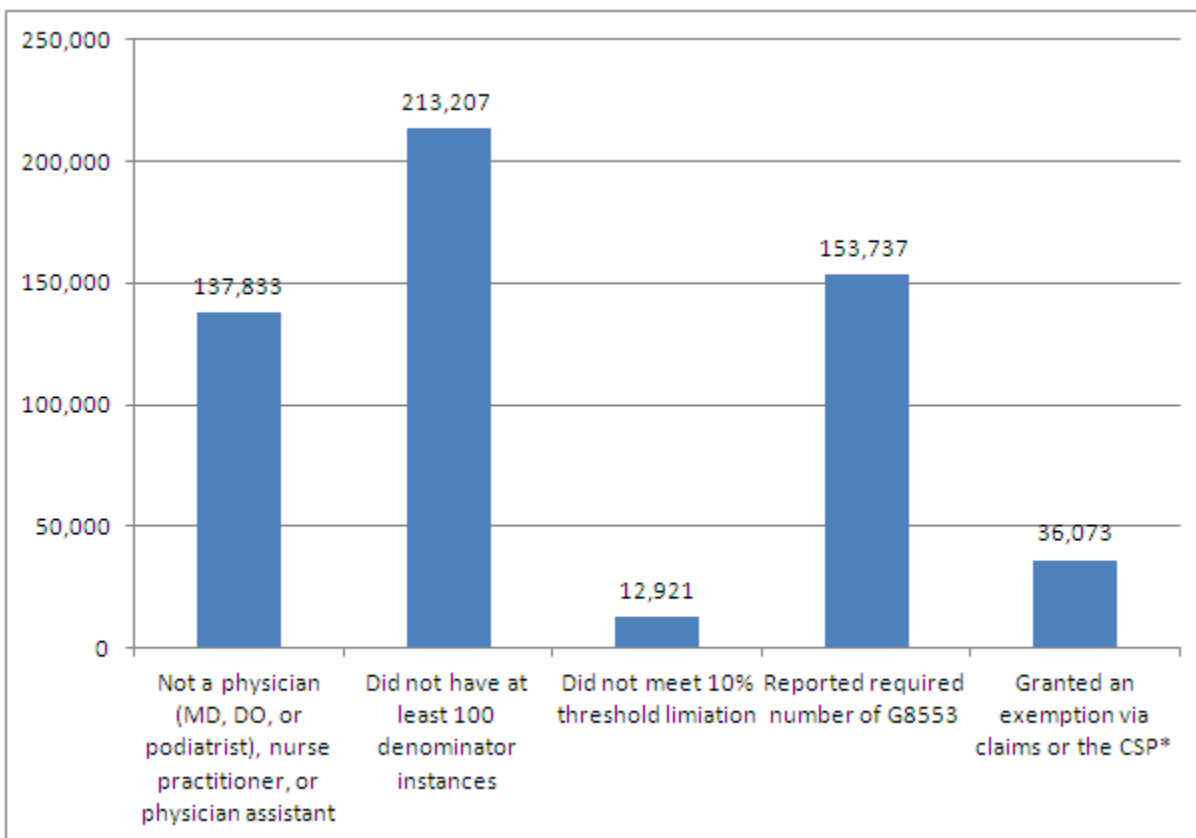
- They were individually participating and reported the G8553 code via claims for at least 10 unique denominator eligible eRx events for services provided during the six-month period from January 1, 2011 through June 30, 2011. Group practices reporting under the GPRO had different minimum denominator eligible eRx events for avoiding the payment adjustment, depending on the size of the practice:
 - 2-10 NPIs: at least 75 G8553 codes submitted
 - 22-25 NPIs: at least 225 G8553 codes submitted
 - 26-50 NPIs: at least 475 G8553 codes submitted
 - 51-100 NPIs: at least 925 G8553 codes submitted
 - 101-199 NPIs: at least 1,875 G8553 codes submitted
 - 200 or more NPIs: at least 2,500 G8553 codes submitted
- They reported G-code G8644 (defined as not having prescribing privileges) at least one time on an eligible claim by June 30, 2011.
- They met and reported a significant hardship exemption via claims by June 20, 2011.
- They met and reported a “Hardship Exemption Request” by November 8, 2011 through the CSP, or via mail for practices participating under the GPRO.

Table 29 presents the specialties with the highest number of eligible professionals subject to the 2012 eRx payment adjustment; Appendix Table A38 lists the number of eligible professionals subject to payment adjustment for all specialties. Family practice and internal medicine had the largest number of eligible professionals (over 20,000 each) subject to the adjustment.

Table 29. Specialties with the Largest Number of Eligible Professionals Subject to the 2012 eRx Payment Adjustment

Specialty	Eligible Professionals Subject to the Payment Adjustment	Percent of Eligible Professionals Subject to the Payment Adjustment
Family Practice	24,474	18.2%
Internal Medicine	20,813	15.4%
Nurse Practitioner	9,051	6.7%
Psychiatry	8,421	6.2%
Podiatrist	6,350	4.7%
Cardiology	5,889	4.4%
Orthopaedic Surgery	5,790	4.3%
Ophthalmology	5,077	3.8%
Physician Assistant	4,491	3.3%
Gastroenterology	3,339	2.5%

A total of 543,545 eligible professionals avoided the 2012 eRx payment adjustment. As seen in Figure 13, the most common reason was not having enough denominator cases (N=213,207), followed by not being in the specialties subject to the adjustment (N=137,833). Another 12,291 eligible professionals were not subject to the adjustment because they did not meet the 10 percent threshold limitation.

Figure 13. Eligible Professionals Exempt from the 2012 eRx Payment Adjustment

* includes eligible professionals who avoided the payment adjustment by reporting a G-code G8644, or were granted a significant hardship exemption via claims or the CSP. Note this total includes 10,226 eligible professionals who were also exempt from the 2012 eRx payment adjustment through one of the first four columns in this chart, as well as 25,847 eligible professionals who would not otherwise be exempt.

Among the eligible professionals who were not excluded from the adjustment based on specialty, having at least 100 denominator cases, or meeting the 10% threshold limitation, 153,737 avoided the penalty by reporting the required number of eRx events during the first half of 2011. In addition, 36,073 received a hardship exemption after submitting a request for exemption via claims (using G-codes G8642, G8643, or G8644) or based on a significant hardship exemption request via the CSP; the majority of these were submitted via the CSP.

V. FEEDBACK REPORTS

A. Background

CMS provides feedback reports for the Physician Quality Reporting System and the eRx Incentive Program each year. Although these reports are not provided simultaneously with the incentives, CMS strives to make feedback reports available as closely as possible to delivery of the incentives. CMS does not require that an eligible professional earn an incentive to furnish a feedback report. Instead, TIN-level feedback reports are available for every TIN under which at least one eligible professional (identified by his or her NPI) submitted Part B MPFS claims with at least one QDC or submitted quality data via registry or EHR for either a Physician Quality Reporting System measure or the eRx Incentive Program measure. There are three types of feedback reports available, depending on whether participation was on an individual basis or if a group practice self-nominated to participate under the GPRO:

- Individual eligible professionals who participate individually in the Physician Quality Reporting System or the eRx Incentive Program can obtain an NPI-level feedback report.
- If a practice did not participate under the GPRO in PQRS or eRx and there was at least one eligible professional who participated in either program, then the practice can obtain TIN-level reports which also include NPI-level data for NPIs within the TIN.
- Group practices that participate under the GPRO are only able to receive TIN-level feedback reports.

B. Accessing Feedback Reports

Feedback reports can be accessed through two different primary processes. TIN-level feedback reports are available from the Physician and Other Health Care Professionals Quality Reporting Portal (Portal). A new process for requesting NPI-level feedback reports was established in 2011, allowing report requests to be made through the Physician Quality Reporting System and eRx Incentive Program Communication Support Page (CSP).²⁶ Feedback reports for multiple program years are available via both of these processes.

TIN-Level Feedback Report Access

2011 TIN-level feedback reports are accessible to practices—also referred to as TIN-representatives (i.e., not individual eligible professionals).

2011 TIN-level feedback reports are available through the Portal. To access these reports, the TIN representative must create an Individuals Authorized Access to the CMS Computer Services (IACS) account, which is required in order for the TIN representative to log on to the Portal. The Portal, accessible via QualityNet, is the secured entry point to access the reports. Each feedback report is safely stored online and is accessible only to persons specifically authorized by that

²⁶ http://www.qualitynet.org/portal/server.pt/community/communications_support_system/234

TIN. For further information regarding this process, see the Physician Quality Reporting System website on the Educational Resources page.²⁷

NPI-Level Feedback Report Access

In 2011 the CSP was made available so that individual eligible professionals can request 2008-2011 NPI-level feedback reports. The CSP is available through the Portal, and does not require an IACS account. For further information regarding this process, see the Educational Resources page of the Physician Quality Reporting System website.

C. Report Content

The 2011 Physician Quality Reporting System feedback reports were packaged at the TIN-level, with individual-level reporting (or NPI-level) and performance information for each eligible professional who reported under that TIN for services furnished during the reporting period. Reports included information on reporting rates, QDC errors, clinical performance, and incentives earned by eligible professionals, with summary information on reporting success and incentives earned at the practice (TIN) level. Reports also included information on the MAV process and any impact it had on the eligible professional's incentive eligibility. Physician Quality Reporting System and eRx Incentive Program participants do not receive claim-level details in the feedback reports.

For both the Physician Quality Reporting System and eRx Incentive Programs, all Medicare Part B claims submitted and all registry, EHR and GPRO data received for services from January 1, 2011 – December 31, 2011 (for the 12-month reporting period) and for services from July 1, 2011 – December 31, 2011 (for the 6-month reporting period) were analyzed to determine whether the eligible professional or group practice qualified for an incentive according to the specific reporting criteria for the respective reporting mechanism.

An annual eRx payment adjustment Interim Feedback Report is made available to those eligible professionals and group practices reporting under the GPRO who submitted at least one eligible instance and were an MD/DO, Podiatrist, Nurse Practitioner, or Physician Assistant. This report includes ten months of Medicare Part B MPFS claims data (from January 1, 2011 – October 31, 2011) to inform the eligible professionals and group practices reporting under the GPRO of their status in meeting the eRx Incentive Program requirements for being a successful electronic prescriber during the reporting period.

²⁷For more detail, see <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/EducationalResources.html>

VI. HELP DESK

A. Background

In 2008, CMS recognized the need for a dedicated Physician Quality Reporting System Help Desk to support the reporting efforts of eligible professionals. The QualityNet Help Desk was tasked with providing such support, and began working with the External User Services Help Desk and all of the Medicare A/B Medicare Administrative Contractor (MAC) and carriers. Professionals who have questions on eligibility, reporting, IACS accounts for Portal access, feedback reports, or payments can contact the appropriate support desk for assistance.

B. Support Desks

1. Previously, the External User Services (EUS) Help Desk provided assistance with obtaining an IACS Security Login for access to the Physician Quality Reporting System Portal. Near the end of 2010, the IACS support for the Physician Quality Reporting System was merged with the QualityNet Help Desk to address vetting for the Security Official role in Organizations, IACS account issues, the new Annual Recertification requirement, assistance in obtaining the data submission role, etc. Eligible professionals still need to contact the EUS Help Desk for issues related to Medicare Enrollment and the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).
2. The CMS A/B MAC and Carrier Provider Contact Centers provide Medicare enrollment and claims submission support. This now includes the responsibility of disbursing the Physician Quality Reporting System and eRx payments to eligible professionals who earned incentives, paid at the TIN level. They answer questions related to payment disbursement, Remittance Advice, and any offsets or adjustments. The A/B MAC and Carriers previously were tasked with accepting requests for individual NPI-level feedback reports through the Alternative Feedback Report Request Process. Instead, the CSP was made available in early 2012 as a means for individual eligible professionals to request 2008-2011 NPI-level feedback reports. The CSP is available through the Portal, and does not require an IACS login. This alternative was implemented in response to some difficulties eligible professionals were having obtaining their IACS login.
3. The QualityNet Help Desk initially consisted of one level of support initially, known as Tier I, which consisted of a team dedicated to issues related to the Physician Quality Reporting System and eRx Incentive Programs. This tier handled questions in the summer and fall of 2008 regarding 2007 program year payments and feedback reports, as well as questions regarding 2008 program year reporting. They were available to answer a range of questions on issues such as eligibility, measures, reporting options, portal login, feedback reports, registries, and payments. In the summer of 2009, a second tier was added, known as Inquiry Support, to address specific measure questions and assist CMS with escalated payment or report issues. This tier was able to provide a level of detailed data review to eligible professionals

who did not qualify for an incentive and needed information in addition to their feedback report. In 2010, a Tier II Inquiry Support team was implemented to focus on providing answers to measures questions and program inquiries for both individual measure reporting as well as measures groups reporting, so that eligible professionals could better understand their feedback reports and use that knowledge to be more successful in future years. The Inquiry Support team became the Tier III Inquiry support level to handle claims detail requests as well as other data specific issues. Near the end of 2010, the IACS support for the Physician Quality Reporting System transitioned to the QualityNet Help Desk (Tier I). This includes vetting for the Security Official role in Organizations, IACS account issues, the new Annual Recertification requirement, assistance in obtaining the data submission role, etc. Eligible professionals still need to contact the EUS Help Desk for issues related to Medicare enrollment and the PECOS system. In 2011, the QualityNet Help Desk at all levels also began to assist with questions related to the eRx payment adjustments for 2012-2014.

Eligible professionals are encouraged to utilize the services provided by these three support desks. The contact information for the three support desks follows:

1. External User Services Help Desk for Medicare enrollment and PECOS questions:
 - Phone: 866-484-8049 (phone)
 - TTY/TDD: 866-523-4759 (Monday - Friday; 7am-7pm EST)
 - Email: EUSupport@cgi.com
2. CMS A/B MAC and Carrier Provider Contact Centers:
 - To get information regarding Contact Centers, see the “Provider Compliance Group Interactive Map” by clicking on the following link <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html>.
3. QualityNet Help Desk for questions on IACS, Portal Login, payments, reports, etc:
 - Phone: 866-288-8912
 - TTY: 877-715-6222
 - Email: Qnetsupport@sdps.org

VII. CONCLUSION

Overall, the Physician Quality Reporting System and the eRx Incentive Program have continuously expanded to ensure participation, increase reporting success, prepare for the payment adjustments associated with these important programs, and to move toward a value-based purchasing system as authorized under section 3007 of the Affordable Care Act.²⁸ The eRx Incentive Program in particular showed impressive growth from 2010 to 2011, perhaps due in part to the new payment adjustment in 2012, which was determined based on 2011 reporting. A similar payment adjustment will be implemented for the Physician Quality Reporting System in 2015, based on reporting conducted in 2013.

The number of measures available to report under the Physician Quality Reporting System continued to expand in 2011, reporting requirements for claims-based reporting were relaxed, and a group reporting option for smaller practices (GPRO II) was added for both programs. These factors may have contributed to increased participation in both programs, even though the average incentive payments earned by incentive eligible participants fell in 2011, as the applicable incentive percent fell from two to one percent. While relatively few Physician Quality Reporting System incentive eligible professionals and specialties attempted to earn the additional 0.5 percent incentive related to participation in a MOCP in 2011, those that did earned an additional incentive payment.

Preliminary data suggest a continued increase in participation for both programs in the 2012 program year. Changes that may impact final 2012 results in these programs include the addition of 68 new measures in the Physician Quality Reporting System (especially in the measures group and EHR reporting mechanisms), the shift to reporting options for small and large group practices under the GPRO, as well as simplification of GPRO reporting requirements for smaller practices. The applicable quality incentive percent for the PQRS will also decrease from one percent to 0.5 percent in 2012.

²⁸See following link for more details: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>

ABBREVIATIONS

Table 30 below contains abbreviations.

Table 30. Abbreviations

Abbreviation	Description
AQA	Ambulatory Care Quality Alliance or AQA Alliance
AMA	American Medical Association
CMS	Centers for Medicare & Medicaid Services
CABG	Coronary Artery Bypass Graft
CAD	Coronary Artery Disease
CPT	Current Procedural Terminology
CSP	Communication Support Page
EHR	Electronic Health Record
eRx	Electronic Prescribing Program
EP	Eligible Professional
ESRD	End Stage Renal Disease
EUS	External User Services
FFS	Fee for Service
GPRO	Group Practice Reporting Option
HIC	Health Insurance Claim number
HCPCS	Healthcare Common Procedure Coding System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IM	Individual Measures
IACS	Individuals Authorized Access to CMS Computer Services
ICD-9-CM	International Classification of Diseases, 9 th Revision, Clinical Modification
LDL-C	Low Density Lipoprotein Control
MAC	Medicare Administrative Contractor
MAV	Measure Applicability Validation
MG	Measures Groups
MD/DO	Doctor of Medicine or Doctor of Osteopathy
MIEA	Medicare Improvements and Extension Act of 2006
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007
MOCP	Maintenance of Certification Program
MPFS	Medicare Physician Fee Schedule
NCQA	National Committee for Quality Assurance
NPPES	National Plan and Provider Enumeration System
NPI	National Provider Identifier

Abbreviation	Description
NQF	National Quality Forum
ORDI	Office of Research, Development, and Information
PCPI	Physician Consortium for Performance Improvement
PQRI	Physician Quality Reporting Initiative
PQRS	Physician Quality Reporting System
PECOS	Provider Enrollment, Chain, and Ownership System
QDC	Quality Data Code
TRHCA	Tax Relief and Health Care Act of 2006
TIN	Taxpayer Identification Number
VBP	Value-Based Purchasing