2009 Reporting Experience

Including Trends (2007 – 2010)

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

4/4/2011

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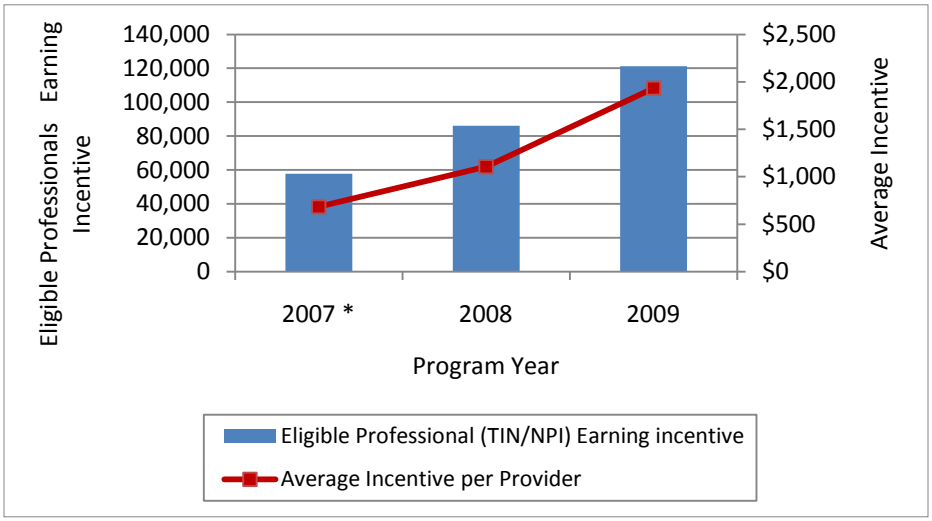
I. EXECUTIVE SUMMARY

As directed by Section 101(b) of division B of the Tax Relief and Health Care Act (TRHCA) of 2006 (Public Law 109423; 120 Stat. 2975), the Centers for Medicare & Medicaid Services (CMS) has implemented two pay-for-reporting programs for medical professionals. The Physician Quality Reporting System (formerly, Physician Quality Reporting Initiative or PQRI) entered its third year in 2009, and has grown substantially from its inception in 2007. The Electronic Prescribing (eRx) Incentive Program was introduced in 2009 as a separate incentive vehicle for Medical Professionals. Prior to 2009, the eRx measure was an individual measure within the overall 2008 Physician Quality Reporting System measure set. These programs reward professionals—based on a percentage of the their total estimated Medicare Physician Fee Schedule (PFS) allowed charges for covered professionals services furnished during the reporting period—for reporting data on standardized measures of quality care. This report summarizes the experience of eligible professionals in these programs in 2009, as well as trends in the program over time, including early results from the 2010 program year. Unless otherwise noted, all tables and figures present 2009 data.

Incentive Payments

- The Physician Quality Reporting System and the eRx Incentive Program combined paid out $382,290,387.62 in 2009 incentive payments.
- A total of $234,282,572.02 (61% of total payments combined) in Physician Quality Reporting System incentive payments were paid by CMS for the 2009 program year; 119,804 eligible professionals, representing 12,647 practices, received incentive payments.
    - 2009 incentive payments were more than two times the total payments in 2008 ($92,406,537.39).
    - The average payment for satisfactorily submitting data was $1,956 per eligible professional and $18,525 per practice.
    - Quality measures were expanded to include a broader set of specialties, incentive amounts increased from 1.5% to 2.0%, and additional methods of reporting and data submission were implemented, which is believed will promote participation.

Figure 1: Eligible Professionals Earning Incentives, by Program Year



* 2007 counts were based on National Provider Identifier Numbers (NPI) whereas subsequent years were based on Tax Identification Numbers (TIN) and NPI combinations

- Over $148,007,815.60 (39% of total payments combined) in eRx incentive payments were paid for the 2009 program year; 48,354 eligible professionals, representing 10,207 practices, received incentive payments.
    - The mean eRx incentive payment was just over $3,000 per eligible professional and $14,501 per practice.

Program Expansions and Eligibility

- Eligible professionals have a number of options for reporting measures, and these options have increased over time:

Table 1: Expansion in Physician Quality Reporting System and eRx Incentive Program Reporting Methods

	Physician Quality Reporting System				eRx	
	2007	2008	2009	2010	2009	2010
Reporting Mechanisms						
Claims-based: Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes
Claims-based: Measures Groups	No	Yes	Yes	Yes	No	No
Registry: Individual Measures	No	Yes	Yes	Yes	No	Yes
Registry: Measures Groups	No	Yes	Yes	Yes	No	No
Electronic Health Record (EHR)	No	No	No	Yes	No	Yes
Group Practice Reporting Option (GPRO)	No	No	No	Yes	No	Yes

- The number of quality measures under the Physician Quality Reporting System have also increased:

Table 2: Number of Measures

	2007	2008	2009	2010
Individual Measures	74	117	153	175
Measures Groups	N/A	4	7	13
EHR	N/A	N/A	N/A	10
GPRO	N/A	N/A	N/A	26

- The measures applicable to the largest number of professionals eligible to report apply to a broad range of specialties since they are not specific to a given diagnosis or existing condition. Although these measures may be widely applicable, based on the nature of the specialty's practice, these measures may or may not apply to an individual professional.

Table 3: Measures Applicable to the Most Eligible Professionals (Claims-Based Individual Measure Reporting)

	Number of Eligible Professionals
#128 Universal Weight Screening and Follow-Up	782,184
#130 Documentation of Current Medications	768,025
#124 HIT - Adoption/Use of EHRs	756,805
#114 Inquiry Regarding Tobacco Use	646,182
#173 Preventive Care and Screening: Unhealthy Alcohol Use - Screening	625,374

- Professionals can participate in the Physician Quality Reporting System through multiple reporting methods:
    - Eligibility for claims-based individual measures reporting is established by having claims meeting the applicable measure criteria for at least one measure.
    - Eligibility for measures groups reporting is established when the professional submits a claim with a code indicating intent to report measures groups.
    - Eligibility for registry reporting is established by a qualified registry having submitted any data for a professional.
- The number of professionals eligible to participate in the Physician Quality Reporting System increased for all of these submission methods—especially the measures groups and registry alternative reporting mechanisms—and topped 1 million in 2009:

Figure 2: Number of Professionals Eligible to Report through Claims-Based Individual Measures, by Year

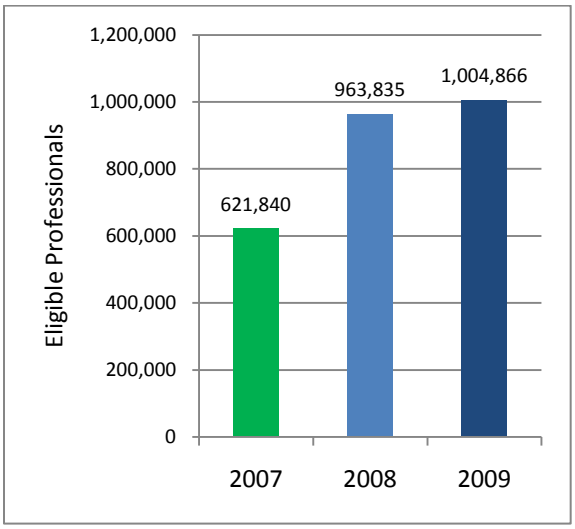
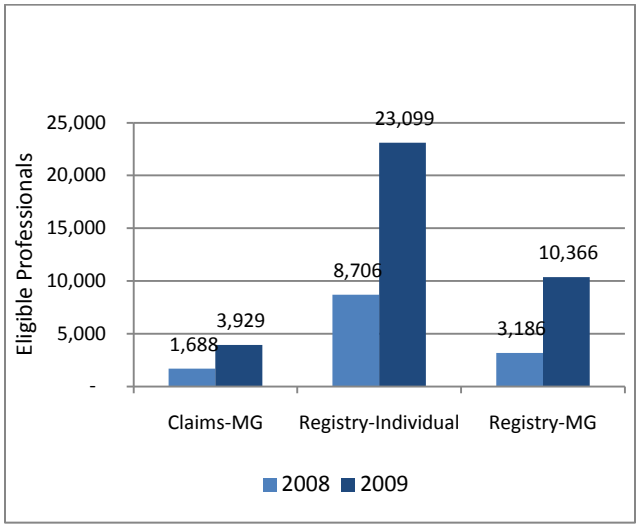


Figure 3: Number of Professionals Eligible to Report through Claims-Based Measures Groups and Registry Reporting, by Year



Note: Eligibility for each of these methods is described above and in more detail in Appendix A of this document.

- The professionals determined eligible to participate in the program through the avenues above were primarily concentrated in certain specialties—such as family practice, internal medicine, cardiology, and ophthalmology. CMS has made every effort to include quality measures that are applicable to all specialties. CMS has requested, through several venues, suggestions of measures to be included in the Physician Quality Reporting System.

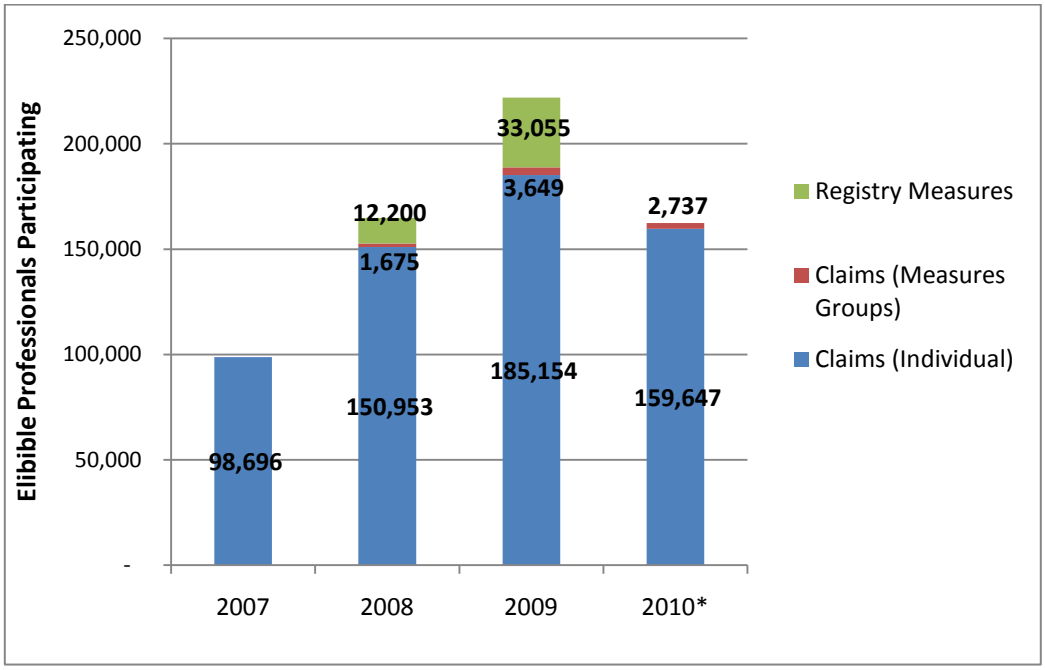
Participation

- In 2009, 210,559 eligible professionals participated in the Physician Quality Reporting System by submitting one or more valid quality-data codes (QDC) for one

of three claims-based methods, or submitting data via one of six registry based methods. The most common method was the claims-based individual measures approach.

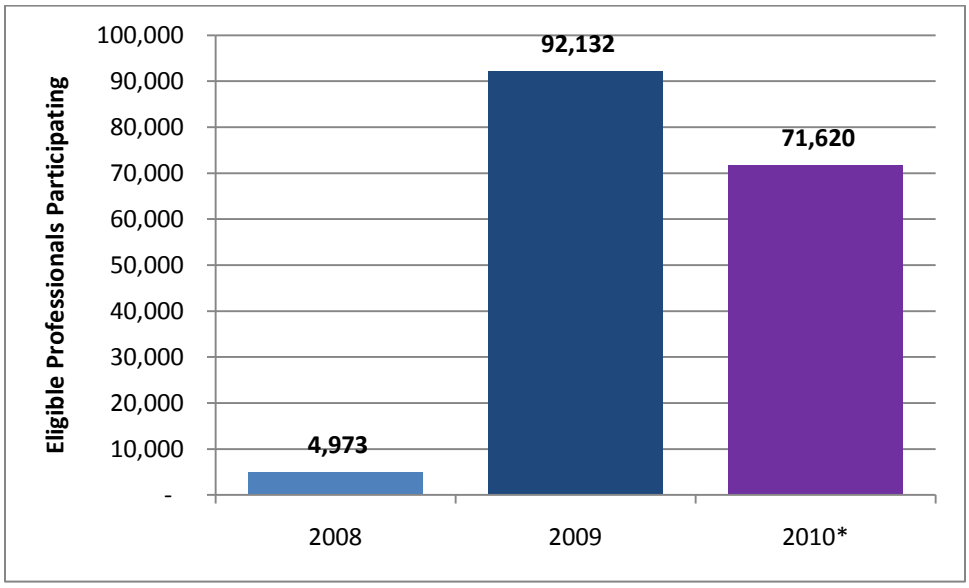
- Participation increased through 2009 in both the Physician Quality Reporting and eRx Incentive Programs
- Preliminary counts for 2010 (representing claims processed through June 25, 2010) indicate further increases in participation in the Physician Quality Reporting System and the eRx Incentive Program

Figure 4: Number of Eligible Professionals Participating, by Physician Quality Reporting System Program Year



* 2010 data shown here includes only claims processed through June 25, 2010.

Figure 5: Number of Eligible Professionals Participating, by eRx Incentive Program Year



* 2010 data shown here includes only claims processed through June 25, 2010. In 2008, eRx was a measure under the Physician Quality Reporting System.

- The participation *rate* (the percent of eligible professionals who submitted at least one valid QDC) among eligible professionals using the claims-based individual method to participate in the Physician Quality Reporting System increased from 15 to 18% from 2008 to 2009.
    - The overall program participation rate was 20% when including registry and measures group methods of reporting.[1]
- In 2009, 13% of eligible professionals participated in the eRx Incentive Program. (Less than 1% of eligible professionals reported the electronic prescribing measure under the Physician Quality Reporting System in 2008).
- The most commonly reported measures groups were Preventive Care and Diabetes. These measures groups are broadly applicable to the Medicare population.
- Some specialties participated more frequently in the 2009 programs than others. It is likely the top participating specialties were typically ones that had specialty societies actively promoting and supporting program participation.
    - Emergency medicine physicians and anesthesiologists had the largest number of participants in the Physician Quality Reporting System claims-based individual measures reporting method. We believe, hospital-based practices most likely have processes in place to capture clinical data accurately therefore allowing quicker uptake of reporting quality measure data.

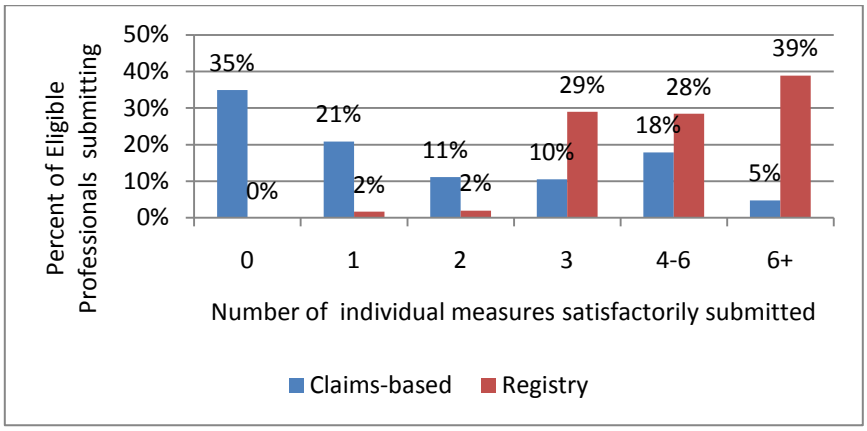
[1] Eligibility for reporting claims-based measures groups is established by an eligible professional submitting an 'intent to participate code'; eligibility to report via registry is established by a qualified registry submitting data for an eligible professional.

- Internists and family practitioners were the most frequent participants using claims-based measures groups and registry submission methods under the Physician Quality Reporting System.[2]
- Internists and family practitioners were also the most common eRx Incentive Program participants, though cardiologists and ophthalmologists had the highest participation rates (28 and 30%, respectively).

Satisfactory Reporting and Challenges to Reporting

- In 2009, 65% of participating eligible professionals satisfactorily reported at least one measure under the claims-based individual measures method, compared with 100% of registry participants. Registry participants submitted more measures than those using the claims-based individual method. Registry participants were required to submit at least three measures for 80% of their eligible cases to satisfactorily report via the registry-based individual method.

Figure 6: Number of Measures Satisfactorily Submitted under the Physician Quality Reporting System



- Among eligible professionals participating via the claims method for submission of individual measures, about 85% of participants submitted some invalid QDCs; only 4% submitted *all* invalid codes. The most common error was submitting a QDC on a claim without a qualifying procedure code for the measure (12% of submissions). Submission of the invalid QDCs are not counted in the analysis for determining incentive eligibility for a participant. It is likely participants are over-reporting on patients not eligible for the measure—such as patients not in the eligible age range for a measure—as a consequence of implementing quality data reporting within the workflow of their practice.
- Half (50%) of professionals participating through the claims-based individual measures method of the Physician Quality Reporting System in 2009 satisfactorily

[2] Refer to section III for a description of measure submission approaches.

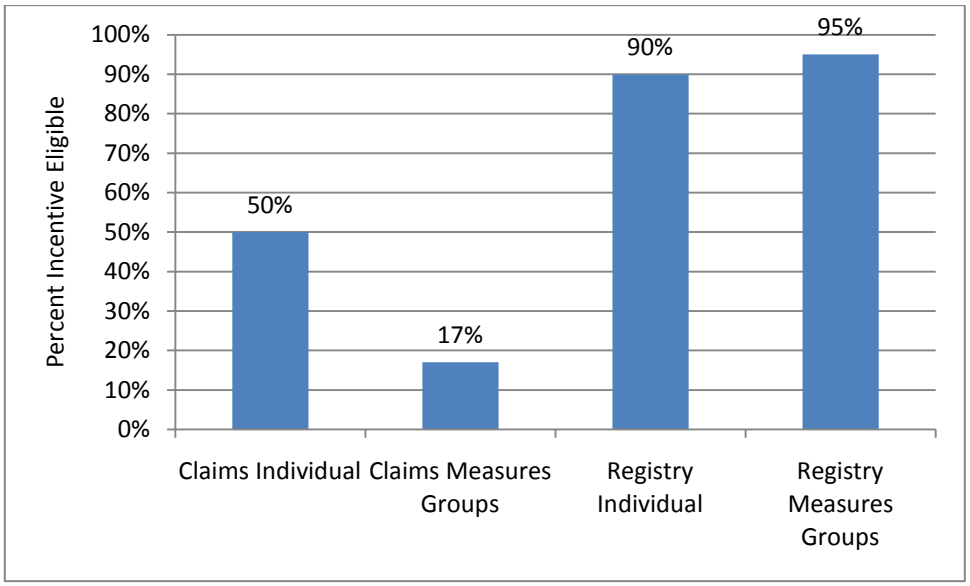
reported, that is, submitted quality measures on at least three measures (or 1 to 2 measures if less apply) for the required 80% of eligible cases.

- There were very few QDC errors in the eRx Incentive Program. 57% of participants in 2009 were successful submitters, submitting on the required 50% of eligible cases.

Incentive Eligibility

- The overall incentive eligibility rate (percent of participating eligible professionals who met the criteria for incentive eligibility) remained relatively stable and was 57% of all eligible professionals in 2009.[3] The table below displays incentive eligibility rates varied by submission method:

Figure 7: Incentive Eligibility Rate in Physician Quality Reporting System 2009



- Among the 50,924 successful submitters (those submitting for at least 50% of eligible instances) under the eRx Incentive Program in 2009, 95% also met the incentive eligibility threshold, and qualified for an incentive payment. To meet the incentive eligibility threshold, an eligible professional's charges associated with eligible cases must be at least 10% of their overall Part B PFS charges.

Trends in Clinical Performance[4]

- While Physician Quality Reporting Program incentive eligibility is based on the eligible professional's ability to meet legislatively-defined reporting thresholds, the program captures clinical performance outcomes as well. Overall, among the 55

[3] Appendix A describes the criteria to qualify for an incentive payment under both programs.

[4] Refer to Section 3.E. of this report for a more detailed discussion of clinical performance.

common measures across the 2007-2009 program years, clinical performance improved by 3.1 percent between 2007 and 2009. The median percentage point change in clinical performance for all measures during this period was an increase of 1.3 percentage points as most measures showed improvement in the clinical performance rate (58 percent) during this period.

- A subset of measures reported across program years 2007-2009 showed substantial percentage point improvement in clinical outcomes (Table 4)

Table 4: Measures with the Highest Percentage Point Increase Between 2007 and 2009 (Claims-Based and Registry Measures Reported)*

Measure	2007 Performance Rate (%)	2009 Performance Rate (%)	Percentage Point Improvement 2007 - 2009
#19 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	52	93	41
#22 Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	54	95	40
#35 Stroke and Stroke Rehabilitation: Screening for Dysphagia	43	77	33
#45 Perioperative Care: Discontinuation of Prophylactic Antibiotics	68	100	32
#8 Heart Failure: Beta-blocker Therapy for LVSD	64	95	31

* Reported by at least 500 eligible professionals in each year.

- Performance for several measures dropped by at least 25 percentage points between 2007 and 2009 including Measures #7 Beta-blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction (MI), #49 Characterization of UI in Women Aged 65 Years and Older and #51 Spirometry Evaluation (each decreased by 30, 28 and 27 percentage points, respectively). One of these measures (#7) changed to a measure that could only be submitted by registries in 2009, and the other measures experienced large increases in the number of eligible professionals reporting them, which may explain the significant drops in measure performance (see section III.E for more discussion of measure performance trends).

- Among a broader set of performance measures reported in both 2008 and 2009 (N=99 measures) the average measure showed improvement in the performance rate of 10.6%, with a median percentage point increase of 0.6 percentage points. Just over half of all measures (55 percent) showed improved performance.

Feedback Reports

- Feedback reports are provided to all practices (identified by their tax identification number or TIN) where at least one eligible professional within the TIN submitted a QDC for at least one measure in the program.

- Reports include information on reporting rates, clinical performance, and incentives earned by individual professionals, with summary information on reporting success and incentives earned summarized at the practice (TIN) level (e.g., all eligible

professionals participating within a practice). Reports also include information on the measure-applicability validation (MAV) process and any impact it had on the eligible professional's incentive eligibility.

Summary

The following table summarizes eligible professionals' reporting experience in the 2009 Physician Quality Reporting System and eRx Incentive Programs.

Table 5: Eligible Professionals' Reporting Experience

	Physician Quality Reporting Claims Individual	Physician Quality Reporting Claims Measures Groups	Physician Quality Reporting Registry	Physician Quality Reporting All Methods	eRx Incentive Program Claims
Eligible	**1,004,866**	**3,929***	**33,413***	**1,006,899**	**669,691**
Participated**	**185,154**	**3,649**	**33,055**	**210,559**	**89,752**
Met 10% Incentive Eligibility Threshold***	N/A	N/A	N/A	N/A	**85,540**
Incentive Eligible	Satisfactory submission of at least 3 measures (or 1-2 subject to MAV) **92,147**	Satisfactory submission of all measures in group **605**	Satisfactory submission of at least 3 measures or all measures in group **30,192**	**119,804**	Satisfactory submission (50% of eligible cases) **48, 254**
Total Payments	**$158,562,435**	**$1,962,586**	**$77,843,758**	**$234,282,572**	**$148,007,816**
Average Payments	**$1,721**	**$3,244**	**$2,578**	**$1,955**	**$3,061**

* Eligible for reporting through claims-based measures groups is defined as those submitting an 'intent to submit' code; eligibility for registry-based reporting is established by qualified registries having submitted data to CMS on behalf of an eligible professional.

** Participation in registry reporting is established by professional qualifying registry having submitted valid data on behalf of an eligible professional; for all other methods and the eRx Incentive Program it means at least one valid quality-data code (QDC) was submitted.

*** Allowed charges from eligible services provided by an eligible professional under the eRx Incentive Program had to be at least 10% of overall PFS allowed charges to meet the "10% incentive eligibility threshold".

In conclusion, the Physician Quality Reporting System, the eRx Incentive Program and payments have grown substantially over time. We believe that participation in these programs suggests a growing interest in reporting information about the quality of healthcare for Medicare beneficiaries. As the measures and reporting methods have expanded, the number of participants has grown rapidly. However the rate of participation among those professionals who are eligible to participate has increased incrementally. Use of alternative reporting methods under the Physician Quality Reporting System such as registry reporting has increased, and the 2010 programs offer new submission methods in both Physician Quality Reporting and eRx Incentive Programs. While fewer eligible professionals participated through the registry method compared to the claims-based individual measures method, those professionals participating via registry

submission were more likely to earn an incentive payment and to earn higher incentive payments. On average, clinical performance on Physician Quality Reporting System measures increased by 3.1 percent between 2007 and 2009 among the 55 common measures to these program years. Over half of the 55 common measures reported showed improvement (58%); the median rate of improvement during this period was 1.3 percentage points. A focus on more recent data indicates that performance continues to improve; among performance measures reported in both 2008 and 2009 (N=99 measures) the average measure showed improvement in performance rate of 10.6%, with a median percentage point increase of 0.6 percentage points.

II. OBJECTIVES OF THIS REPORT

As originally directed by Section 101(b) of division B of the Tax Relief and Health Care Act (TRHCA) of 2006 (Public Law 109-423; 120 Stat. 2975), the Centers for Medicare & Medicaid Services (CMS) has implemented two pay-for-reporting programs for medical professionals. The Physician Quality Reporting System entered its third year in 2009, and has grown substantially from its inception in 2007. The Electronic Prescribing (eRx) Incentive Program began as a standalone program in 2009. Currently, these programs reward professionals—based on a percentage of the professional's total estimated part B Medicare PFS allowed charges for covered professional services furnished during the applicable reporting period —for reporting data on standardized measures of quality care based on data from the previous year.[5] This report summarizes the experience of eligible professionals in these programs in 2009, as well as trends in the programs over time.

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 feedback reporting under the Physician Quality Reporting System and Help Desk experience. Section VIII concludes and describes upcoming changes to the programs. A separate document contains descriptions of data and methods (Appendix A) as well as detailed results tables for both programs (Appendices B and C).

This report focuses on the reporting experience of eligible professionals. It also provides summary-level information on quality measure performance. Professionals participating in the Physician Quality Reporting System receive feedback reports on their performance compared with national performance percentiles for the claims-based individual measures method of participation, as described in Section V.

This report uses the term "eligible professional" to indicate all physicians and other health care professionals designated as eligible to participate in the Physician Quality Reporting System. These professionals are defined in a downloadable document available on the CMS website[6] and include professionals who furnish PFS covered services to Medicare Part B (including Railroad Retirement and Medicare Secondary Payer) beneficiaries for whom selected measure(s) are applicable, regardless of whether they have signed a Medicare participation agreement to accept assignment on all claims. In addition, the unit of analysis for describing eligible professional's experience is a combination of the professional's National Provider Identifier (NPI) and the Tax Identification Number (TIN) the NPI is billing under; that is at a "TIN/NPI" level (see Appendix A for more detail.) Finally, data are summarized at both the program (inclusive of all submission methods) and submission method level. Unless otherwise noted, data are reported at the program-level.

[5] For example, 2009 payments to eligible professionals reflected data for services in calendar year 2008.

[6] Refer to the download section of the Overview page on the CMS website for Physician Quality Reporting.

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 rewards the value of care provided, rather than the quantity of services furnished. To this end, the Physician Quality Reporting System measures are intended to define, standardize and improve the quality of health care services that add value to the care provided to Medicare beneficiaries. The incentive, offered to professionals for satisfactorily reporting quality data with regard to the requirements under the Physician Quality Reporting System, is 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" or "MIEA") of the Tax Relief and Health Care Act of 2006 (Public Law 109-423; 120 Stat. 2975), commonly known as TRHCA, which was enacted on December 20, 2006. CMS initially referred to the physician quality reporting system authorized by TRHCA as the "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. Professionals who chose to participate in the 2007 Physician Quality Reporting System and satisfactorily reported on a designated set of quality measures—by placing specified quality-data codes (QDCs) on claims—for dates of service from July 1 through December 31, 2007, were eligible for an incentive, subject to a cap, of 1.5% of total estimated part B allowed charges for covered professional (Medicare PFS) services furnished July 1 through December 31, 2007.

Program Evolution

Measures for the 2007 program were identified in the TRHCA as those quality measures developed under the Physician Voluntary Reporting Program as published on the CMS web site as of the date of enactment of the TRHCA, but the statute also provided that such measures could be changed by the Secretary based on the results of a consensus-based process in January 2007 and if such changes were subsequently 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) and had to receive consensus endorsement for adoption. The AMA-PCPI actively participated with CMS in defining reporting specifications for the measures used in the 2007 program and developing instructions on how the measurement data would be captured through the claims based reporting process using Current Procedural Terminology (CPT) II codes.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), enacted on December 29, 2007 (Pub. Law 110-173) further extended the quality reporting system through 2008 and 2009. Furthermore MMSEA:

- Authorized incentive payments of 1.5% of total allowable charges for covered PFS services furnished during 2008
- Removed the cap on the total earned incentive amount previously mandated by TRHCA
- Required that CMS establish alternative reporting periods and alternative criteria for satisfactory reporting for: (1) groups of measures and (2) quality measurement information via participation in a clinical data registry.

The set of quality measures for the 2008 program comprised 119 measures: 117 clinical measures and 2 structural measures (use of electronic health records and electronic prescribing). The 119 measures for 2008 had undergone a consensus-based review and approval process specified in the 2008 PFS Final Rule and had been endorsed or adopted by a consensus organization, such as the National Quality Forum (NQF) or the AQA Alliance (AQA). These 119 measures applied to all clinical disciplines and applied to procedures or visits that accounted for 95% of Medicare Part B spending in 2008.

The basic structure of the Physician Quality Reporting System remained the same for 2009, though the number of measures and reporting methods were expanded as described in more detail below. MMSEA also increased the incentive eligibility amount from 1.5% to 2.0% of total estimated part B allowed charges for covered professional services during the reporting period.

CMS added 52 new quality measures and removed 18 measures, for a total of 153 measures in 2009, an increase from 119 measures in 2008. Eighteen of the 153 measures were reportable through the registry-based reporting methods only; four measures could only be reported as a group. For 2009, measures and measures groups that were complex for reporting via claims were deemed to be reportable via registry only.

A Measure Applicability Validation (MAV) process was applied for those eligible professionals who satisfactorily submit QDCs for fewer than three Physician Quality Reporting measures to determine whether they should have submitted QDCs for additional measures. The MAV process checks that an eligible professional was not eligible for other measures through two tests. First, if an eligible professional is reporting on at least one measure within a cluster of measures clinically or eligible professional service related, it is thought other closely-related measures may also be applicable to the eligible professional's practice (clinical relation test). Second, the eligible professional must have had a certain number of eligible instances for those measures the eligible professional should have reported based on the clinical relation test (minimum threshold test).[7] Those who failed the validation process did not earn an incentive payment.

Measures groups were introduced in 2008 and expanded in 2009. Measures Groups are a subset of four or more Physician Quality Reporting measures that have a particular clinical condition or focus in common. The program retained three of the four measures groups from 2008—diabetes mellitus (six measures), chronic kidney disease (five measures), and preventive care (nine measures)—and retired one group (ESRD). The measures within the diabetes mellitus and chronic kidney disease groups changed from 2008. The following measures groups were added

[7] The threshold for eligible instances was 50 in 2007, 30 in 2008, and 15 in 2009.

for 2009: rheumatoid arthritis (six measures), coronary artery bypass graft (CABG) surgery (ten measures), perioperative care (four measures), and back pain (four measures). While both claims-based and registry-based reporting methods had a measures group option, the CABG group could only be reported through the registry-based measures group option. The measures in the back pain measures group could only be reported as a group and not individually. Another change to measures groups reporting was that each had a QDC indicating if all actions for each measure were met; eligible professionals could report one code rather than individual quality codes for each measure. For 2010, measures groups were further modified to remove the consecutive requirement and require reporting on a unique patient sample of 30 beneficiaries during the program year (Table 7). This change will be applied to both claims and registry based measures groups. This should help increase incentive eligibility rates since identification of the eligible cohort of consecutive beneficiaries was problematic for the claims-based method of participation.

CMS further expanded the Physician Quality Reporting System in 2010 by adding the EHR-based and Group Practice Reporting Option (GPRO) reporting mechanisms. Table 6 presents the reporting mechanisms available in each program year.

Table 6: Physician Quality Reporting System: Reporting Options by Program Year

	2007	2008	2009	2010
Reporting Mechanisms				
• **Claims**	Yes	Yes	Yes	Yes
o Individual Measures	Yes	Yes	Yes	Yes
o Measures Groups	No	Yes	Yes	Yes
• **Registry**	No	Yes	Yes	Yes
o Individual Measures	No	Yes	Yes	Yes
o Measures Groups	No	Yes	Yes	Yes
• **Electronic Health Record (EHR)**	No	No	No	Yes
• **Group Practice Reporting Option (GPRO)**	No	No	No	Yes

Table 7 summarizes changes in incentive percents, measures, reporting options and reporting criteria between 2007 and 2010.

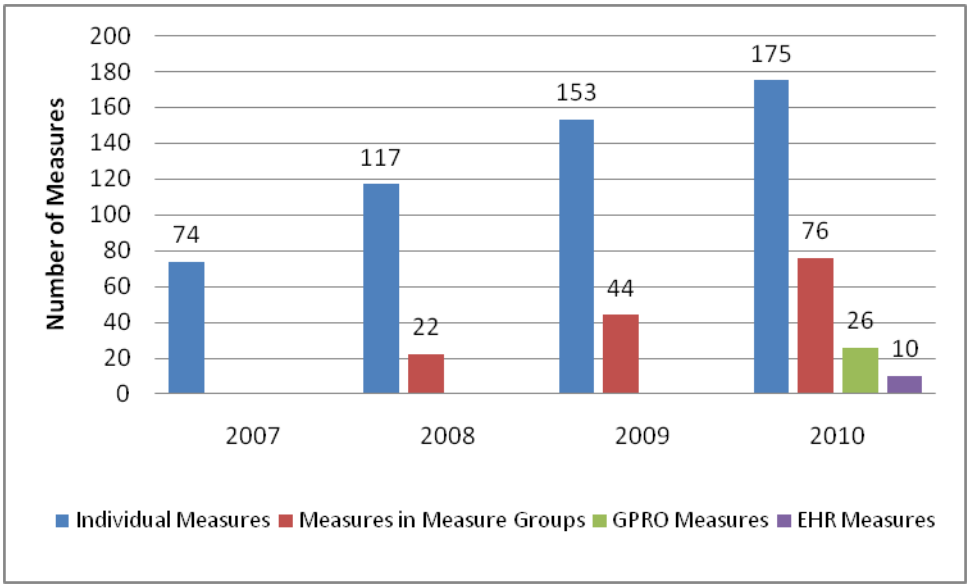
Table 7: Physician Quality Reporting System: Incentives, Measures and Reporting Criteria

	2007	2008	2009	2010
Incentive Payment	1.5% (with cap) TRHCA	1.5% MMSEA	2.0% MIPPA	2.0% MIPPA
Number of Measures and Measures Groups	74 Clinical Measures	117 Clinical Measures 2 Structural Measures 4 Measures groups	152 Clinical Measures 1 Structural Measure 7 Measures groups	178 Clinical Measures 1 Structural Measure 13 Measures groups
Individual Measures Reporting Criteria	3 measures (or 1-2 measures) subject to MAV and 80% of eligible instances	Same as 2007	Same as 2007 (registry has to report a minimum of 3 measures)	Same as 2007 (registry has to report a minimum of 3 measures)
Reporting Period	6 Months (July 1 – Dec 31)	12 Months (Jan 1 – Dec 31) 6 Months (July 1 – Dec 31)	12 Months (Jan 1 – Dec 31) 6 Months (July 1 – Dec 31)	12 Months (Jan 1 – Dec 31) 6 Months (July 1 – Dec 31)
Measures Group Reporting Criteria	N/A	Report on all measures in at least 1 MG for: • 80% eligible Medicare patients (no minimum) or • 15 or 30 consecutive patients (non-Medicare patients accepted for registry-based reporting only)	Report on all measures in at least 1 MG for: • 80% eligible Medicare patients (min of 15 or 30 patients) or • 30 consecutive patients (non-Medicare patients accepted for registry-based reporting only)	Report on all measures in at least 1 MG for: • 80% eligible Medicare patients (min of 8 or 15 patients) or • 30 patients (non-Medicare patients accepted for registry-based reporting only)

As Tables 6 and 7 shows, CMS expanded the avenues for participation by introducing new reporting options starting in 2008. These options have been expanded and refined over time. For example, for 2010 measures groups, participants who choose the "30 patient" option no longer have to report on consecutive patients. The GPRO and EHR methods added in 2010 offer new avenues for participation.

CMS also continued to expand the number of measures in the Physician Quality Reporting System each year in order to maximize eligible professionals' ability to participate:

Figure 8: Number of Measures in the Physician Quality Reporting System, by Reporting Approach and Year



Note: There were four measures groups in 2008 with a total of 22 measures within those measures groups, seven in 2009 with a total of 44 measures within those measures groups, and 13 in 2010 with a total of 76 measures within those measures groups. The measures in the individual measures and measures in measures groups are not mutually exclusive.

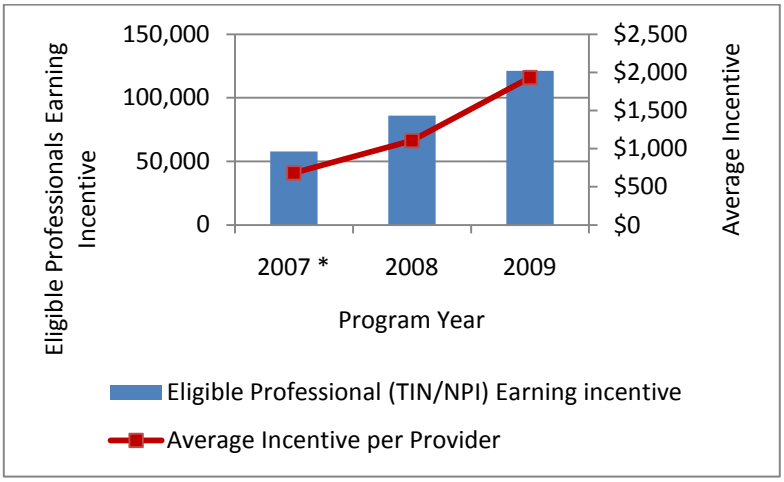
B. Incentive Payments

The incentive earned by each individual eligible professional satisfying reporting criteria for 2009 was 2.0% of the eligible professional's total estimated Medicare Part B PFS allowed charges for covered services (professional and technical services) billed under the individual's TIN/NPI during the January - December OR July - December 2009 reporting period. Overall, a total of $234,282,572.02 in Physician Quality Reporting System incentive payments (62% of the $382,290,387.62 total of both the Physician Quality Reporting System and eRx Incentive Programs) was paid for the 2009 program year, to 119,804 eligible professionals representing 12,647 practices[8]. Due in part to the increased number of measures, a rise in participants, and the increase in the bonus percent (from 1.5% to 2.0% of Medicare Part B PFS allowed charges), the 2009 incentive payments were more than two times the total payments in 2008 ($92,406,537.39).

The average payment for the Physician Quality Reporting System was $1,956 per eligible professional satisfactorily submitting data on quality measures and $18,525 per practice. Figures 9 and 10 show how the average incentive and the number earning incentives have grown at both the eligible professional and the practice level.

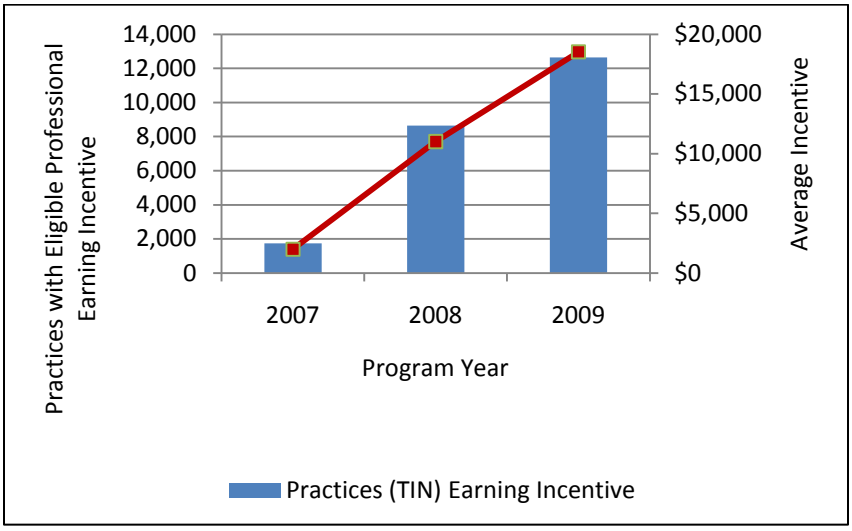
[8] There were 1,397 TIN/NPI who met incentive eligibility criteria for registry-based methods under the Physician Quality Reporting System, but who had no Medicare Part B Physician Fee Schedule charges in 2009 and therefore had an incentive amount of $0.00. These professionals are not included in the counts of incentive eligible professionals in this report.

Figure 9: Eligible Professionals Earning a Physician Quality Reporting System Incentive and Average Amounts by Program Year



* 2007 counts were based on National Provider Identifier Numbers (NPI) whereas subsequent years were based on Tax Identification Numbers (TIN) and NPI combinations.

Figure 10: Practices (TIN) with an Eligible Professional Earning a Physician Quality Reporting System Incentive and Average Amounts (per TIN) by Program Year



Incentive payments under the Physician Quality Reporting System vary by specialty due to differences in incentive eligibility rates and underlying Medicare Part B PFS allowed charges. Appendix Table B-1 displays the distribution of incentive amounts by specialty.

The average potential incentive (using 2009 charges) that could be earned by professionals can be calculated by dividing Medicare PFS total allowed charges for covered professional services for a given specialty by the number of professionals in that specialty eligible to participate in claims-based reporting in 2009 and taking 2.0% of this value. Appendix Table B-2, which displays each specialty's average potential incentive for 2009 along with each specialty's participation rate, shows that the average potential incentive exceeds $3,000 for 13 specialties.

C. Participation

How to Participate

CMS has provided multiple resources on the Physician Quality Reporting System website to assist eligible professionals participating in the program. The *2009 Implementation Guide* gives guidance on how to determine which measures to report, the reporting method, and claims-based reporting principles. CMS has also provided Frequently Asked Questions (FAQ's) covering a wide range of topics regarding the program.

In 2009, there were nine methods for submitting data to the Physician Quality Reporting System:

- Claims-Based Individual Measures 12-months. Eligible professionals could report quality-data codes—CPT II codes or G-codes—for 132 individual measures via claims. To qualify for an incentive, eligible professionals had to report on 3 or more measures (or 1-2 subject to a measure-applicability validation, or MAV, review to assure only those measures applied) for at least 80% of reporting opportunities, for the period January 1 through December 31, 2009.

- Claims-Based Measures Groups - 80% 12-months. Eligible professionals report on all measures with any of the seven measures groups applicable to them. To be incentive eligible, eligible professionals had to report at least one measures group for 80% of applicable Medicare Part B FFS patients (with a minimum of 30 patients during the period).

- Claims-Based Measures Groups - 80% 6-months. Same as method 2 except with a 6-month period of July 1 through December 31, 2009 and a minimum of 15 patients during the period.

- Claims-Based Measures Group - 30 Consecutive. Eligible professionals had to report all measures within at least one measures group, for 30 consecutive Medicare Part B FFS patients of each eligible professional, during the period January 1 through December 31, 2009.

- Registry-Based Reporting - Individual Measures 12-month. Eligible professionals submit data through one of 69 qualified registries. Eligible professionals had to report on 3 or more measures for 80% of applicable Medicare Part B FFS patients of each eligible professional, for the period January 1 through December 31, 2009.

- Registry-Based Reporting - Individual Measures 6-month. Same as registry-based individual 12-month reporting, except only over the period July 1 through December 31, 2009.

- Registry-Based Reporting – Measures Groups 80% 12-month. Eligible professionals had to report, through a qualified registry, all measures within at least one measures group for 80% of applicable Medicare Part B FFS patients, for the period January 1 through December 31, 2009, with a minimum of 30 patients.

- Registry-Based Reporting – Measures Groups 80% 6-month. Same as registry-based measures groups 80% 12-month reporting, except only over the period July 1 through December 31, 2009, with a minimum of 15 patients.

- Registry-Based Reporting - Measures Groups 30 Consecutive. Eligible professionals had to report, through a qualified registry, all measures within at least one measures group for 30 consecutive patients of each eligible professional. Patients may include, but may not be exclusively, non-Medicare Part B FFS patients.

Participation Results

In 2009, there were 1,006,899 professionals eligible to participate in the Physician Quality Reporting System across all claims and registry approaches.[9] The majority of professionals were eligible to participate via claims-based individual measures (1,004,866). Appendix Table B-3 lists the number of professionals eligible for each reporting approach from 2007 through 2009, and Appendix Tables B-4 through B-7 present the numbers eligible by specialty for each of the main methods—claims-based individual measures, claims-based measures groups, registry individual, and registry measures groups.

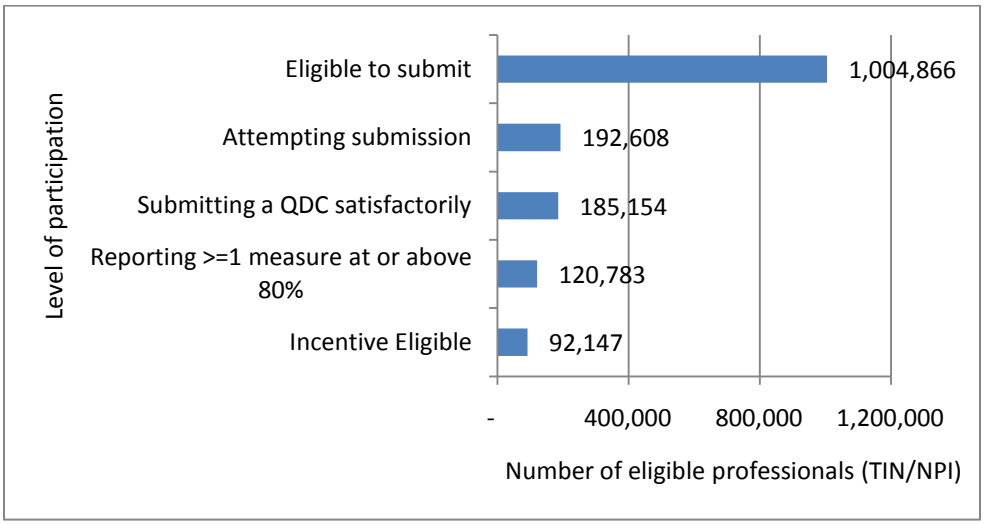
Overall, 210,559 professionals (20.9% of those eligible to participate) participated by submitting at least one valid QDC on an eligible instance in the 2009 Physician Quality Reporting System; 299 eligible professionals participated through more than one submission method. Appendix Table B-8 shows that participation varied considerably by reporting method and ranged from 18.4% of all eligible professionals reporting claims-based individual measures to 99.9% of all eligible professionals participating via registry measures groups.[10] Historically, the overwhelming majority of professionals participated via claims-based individual measures; however, participation via measures groups has grown since their introduction in 2008.

Figure 11 shows the level of participation for claims-based individual measures in 2009. While over one million professionals were eligible to participate in the Physician Quality Reporting System in 2009, fewer than one in five professionals attempted submission of at least one QDC. Of the 192,608 professionals attempting to submit via the claims-based individual measures method, most professionals (96%) were able to submit at least one QDC satisfactorily, indicating that data were submitted without a data error. Ultimately, about 9% of the population of professionals eligible to submit to the Physician Quality Reporting System received an incentive in 2009. Incentive eligibility and payments are described in greater detail in subsequent sections of this report.

[9] Appendix A provides definitions of program eligibility, program participation and incentive eligibility.

[10] "Eligibility" for registry-based reporting is established by a qualified registry having submitted data for an eligible professional; therefore, the participation rate for registry reporting methods is very high.

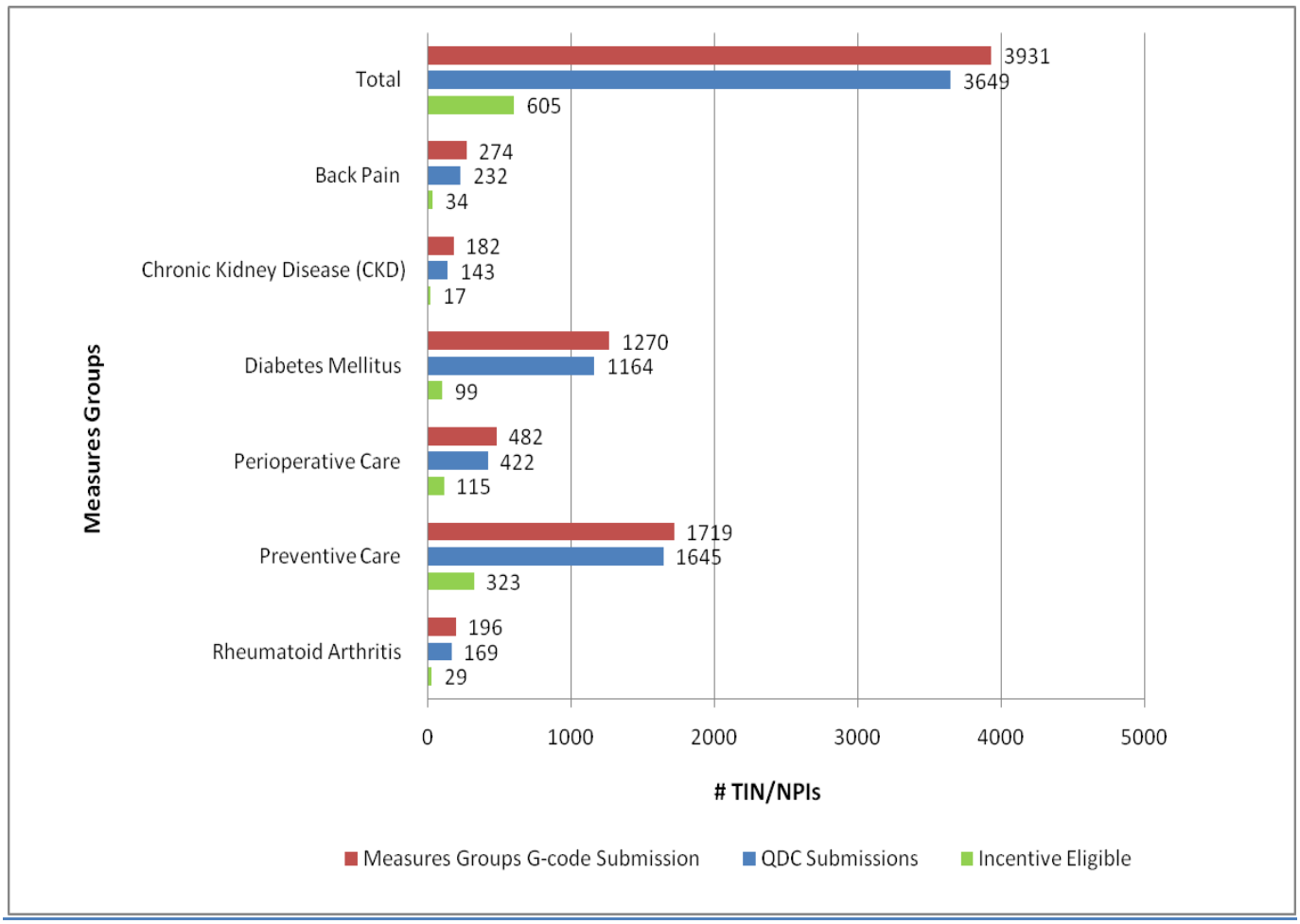
Figure 11: Claims-Based Individual Measures: Participation in Physician Quality Reporting System in 2009



Use of Measures Groups and Registries

The number of measures groups in the Physician Quality Reporting System expanded from four to seven between 2008 and 2009. The number of professionals participating via claims-based measures groups grew by 159% between 2008 and 2009. Figure 12 shows the number of professionals submitting intent G-codes, submitting QDCs and attaining incentive eligibility within each measures group; the preventive care measures group had the most eligible professionals submitting QDCs and the most eligible professionals earning an incentive payment. Registry-based measures groups grew at an even more rapid rate over the same time period; the number of eligible professionals participating in registry measures groups increased by 227%. The preventive care and diabetes measures groups had the highest number of eligible professionals submitting data via registry. These two measures groups are broadly applicable to the Medicare population and are treated by two of the most common specialties (Family Medicine and Internal Medicine) reporting measures groups.

Figure 12: Claims-Based Measures Groups: Participation in Physician Quality Reporting System in 2009



Note: 'Measure Groups G-code Submission' indicates eligible professionals submitted a G-code indicating intent to report on a given corresponding measures group.

The use of registry reporting also increased from 2008 to 2009. In 2008, 31 qualified registries submitted on behalf of eligible professionals, and in 2009, 69 qualified registries submitted data. Table 8 displays the registries representing the most eligible professionals submitting data to the Physician Quality Reporting System in 2009.[11] 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.

[11] A complete listing of qualified registries is available on the Physician Quality Reporting System website under the Alternative Reporting Mechanisms page.
https://www.cms.gov/PQRS/20_AlternativeReportingMechanisms.asp#TopOfPage

Table 8: 2009 Registries Submitting for the Most Eligible Professionals (Individual Measures, 12 Months)

Registry Name	Eligible Professionals Submitting to Registry
DocSite	4,885
Wisconsin Collaborative for Healthcare Quality	2,555
Outcome™ PQRI Registry	2,458
Epic Systems Corporation	2,348
Team Praxis, LLC	2,310
GE Healthcare	1,629
Central Utah Informatics	1,601
CINA Quality Suite	1,161
NextGen_Registry	1,095
NCQA	957

Participation by Specialty[12]

In terms of absolute numbers of professionals submitting QDC data through the claims-based individual measures, emergency medicine physicians had the largest representation among all professional specialties and also had a high rate of participation (63%). Hospital-based practices most likely have current processes in place to capture clinical data accurately therefore allowing quicker uptake of reporting quality measure data. Family practitioners also had a very large number of professionals submitting, but the percentage of eligible family practitioners submitting was lower than average (Table 9). There are many measures in the Physician Quality Reporting System that apply to Emergency Medicine and Family Practice. Thus, these specialties are able to easily identify applicable measures for a majority of their Medicare population. Appendix Table B-9 shows eligibility and participation rates by specialty across all reporting methods. Tables displaying participation rates by specialty by submission method for 2007 through 2009 can be found in Appendix Tables B-10 through B-13.

[12] "Specialty" is the primary specialty listed for the NPI in the National Provider and Plan Enumeration System (NPPES); see Appendix A for details.

Table 9: Specialties with the Largest Number of Eligible Professionals Participating in the 2009 Physician Quality Reporting System - Claims-Based Individual Measures

Specialty	Number Eligible Professionals Eligible	Number Eligible Professionals Submitting	Percent Eligible Professionals Submitting
Emergency Medicine	49,372	30,988	62.8%
Anesthesiology	42,524	17,488	41.1%
Family Practice	90,652	14,607	16.1%
Internal Medicine	91,830	14,228	15.5%
Nurse Anesthetist	40,647	11,905	29.3%
Radiology	37,383	11,796	31.6%
Physician Assistant	42,085	8,951	21.3%
Other Non-MD/DO	43,992	7,163	16.3%
Ophthalmology	19,014	7,068	37.2%
Nurse Practitioner	44,586	6,110	13.7%

Internal medicine and family practitioners had the highest number of submissions of claims-based measures groups. Although, the percentage of professionals eligible for measures groups who submitted QDC data was generally high for all specialties (Table 10). Overall participation using this method is quite high because it is calculated as the number of eligible professionals submitting any valid QDC data *among* those who had submitted a QDC for their intent to participate in the measures group.

Table 10: Specialties with the Largest Number of Participants in the 2009 Physician Quality Reporting System - Claims-Based Measures Groups

	Number Professionals Eligible	Number Eligible Professionals Submitting	Percent Eligible Professionals Submitting
Internal Medicine	1,034	1,001	96.81%
Family Practice	984	929	94.41%
Orthopedic Surgery	271	246	90.77%
Nurse Practitioner	176	167	94.89%
Rheumatology	154	149	96.75%
General Surgery	159	145	91.19%
Other Non-MD/DO	173	145	83.82%
Physician Assistant	124	119	95.97%
Nephrology	122	118	96.72%
Endocrinology	74	72	97.30%

Note: 'Percent Eligible Professionals Submitting' is calculated as the number of eligible professionals submitting any valid QDC data among those who had submitted a QDC for their intent to participate in the measures group.

Submission of any valid quality data through registries was most frequent among family practitioners and internal medicine physicians with several non-MD/DO specialties appearing among the specialties with the highest number of professionals submitting data (Table 11).

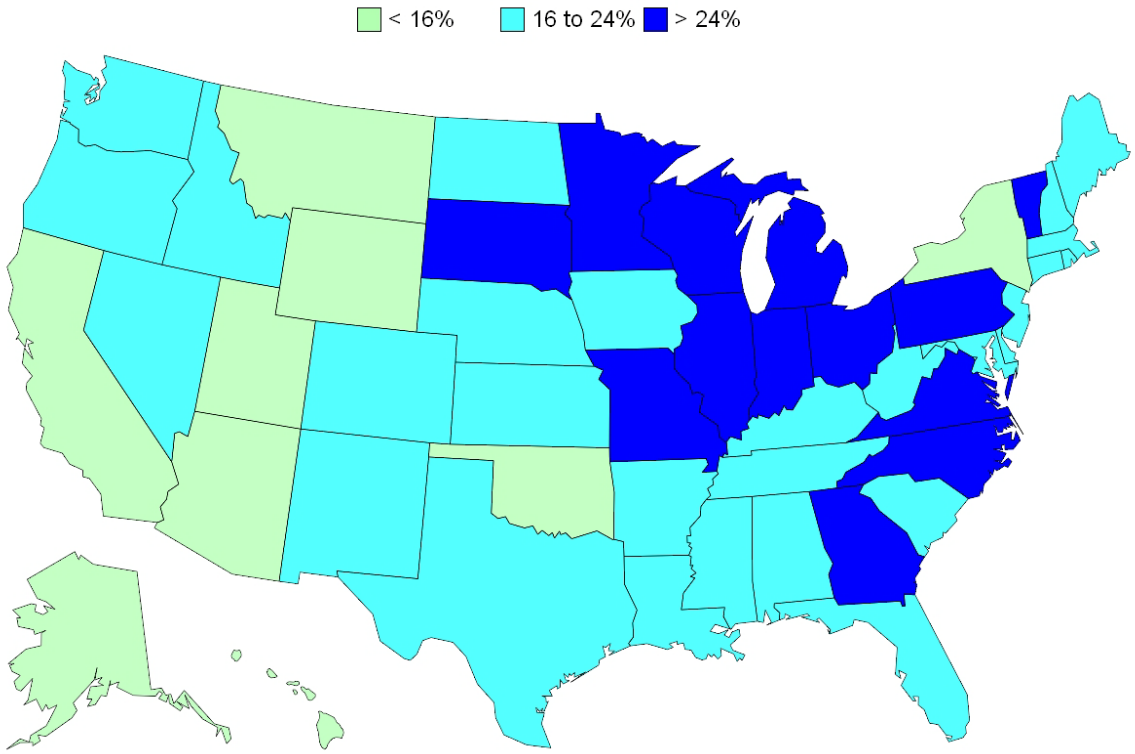
Table 11: Largest Number of Specialties Participating in the 2009 Physician Quality Reporting System - Registries

Specialty	Number Professionals Eligible	Number Eligible Professionals Submitting	Percent Eligible Professionals Submitting
Family Practice	7,381	7,365	99.78%
Internal Medicine	6,514	6,472	99.36%
Cardiology	2,020	2,007	99.36%
Nurse Practitioner	1,646	1,622	98.54%
Physician Assistant	1,255	1,243	99.04%
Other Non-MD/DO	1,089	1,063	97.61%
Nephrology	1,035	1,033	99.81%
OB/GYN	988	973	98.48%
Orthopedic Surgery	917	916	99.89%
General Surgery	717	709	98.88%

Geographic Variation in Participation

Figure 13 demonstrates the geographic variation in participation in the Physician Quality Reporting System in 2009, including all reporting methods.[13] Participation rates across all methods in the program were highest in the Midwest and Southeast. Participation was lowest (<16%) in Alaska, Arizona, California, Hawaii, Montana, New York, Oklahoma, Utah, and Wyoming. State-by-state results are found in Appendix Table B-14.

Figure 13: Eligible Professional Participation in Physician Quality Reporting System by State, 2009 (All Reporting Methods)



Participation represents the number of eligible professionals submitting (numerator) divided by number of eligible professionals (denominator).

[13] State is identified as the state associated with the eligible professional (NPI) in the National Plan and Provider Enumeration System (NPPES). See Appendix A for details.

Participation by Measure

Many measures in the Physician Quality Reporting System were selected because they were applicable to a wide range of professionals and Medicare beneficiaries. The measures applicable to the highest number of eligible professionals—with the most professionals who met the denominator condition for a specific measure based on claims—were preventive measures (Table 12). These measures do not require a specific diagnosis to be applicable to a certain clinical condition.

Table 12: Physician Quality Reporting System Measures Applicable to the Largest Numbers of Eligible Professionals, 2009 (Claims-Based Individual Measures)

Measure	Eligible Professionals Eligible to Submit[a]
#128 Universal Weight Screening and Follow-Up	782,184
#130 Documentation of Current Medications	768,025
#124 HIT - Adoption/Use of EHRs	756,805
#114 Preventive Care and Screening: Inquiry Regarding Tobacco Use	646,182
#173 Preventive Care and Screening: Unhealthy Alcohol Use - Screening	625,374
#47 Advance Care Plan	616,182
#154 Falls: Risk Assessment	605,832
#115 Preventive Care and Screening: Advising Smokers to Quit	580,067
#111 Pneumonia Vaccination for Patients 65 years and Older	567,994
#113 Colorectal Cancer Screening	563,724

[a] The # of unique TIN/NPI combinations meeting denominator criteria for the Physician Quality Reporting System measure.

Table 13 lists the measures with the most eligible professionals submitting data via claims. Although a large number of professionals submitted data for these measures, several were submitted by less than 10% of those to which the measure was applicable, notably Measure #124 (Adoption/Use of EHR), Measure #1 (Diabetes Mellitus: Hemoglobin A1c Poor Control) and Measure #2 (Diabetes Mellitus: Low Density Lipoprotein Control). Although Measure #124 was only reported by 3.5 percent of professionals who had qualifying claims data, this measure may only be reported by those eligible professionals that have an EHR system as described in the measure.

Table 13: Physician Quality Reporting System Measures with the Largest Numbers of Eligible Professionals Submitting, 2009 (Claims-Based Individual Measures)

Measure	Number Eligible Professionals Submitting	Percent Eligible Professionals Submitting
#54 ECG Performed for Non-Traumatic Chest Pain	37,688	57.5%
#57 Community-Acquired Bacterial Pneumonia (CAP): Assessment of Oxygen Saturation	36,197	17.8%
#58 Community-Acquired Bacterial Pneumonia (CAP): Assessment of Mental Status	32,199	15.8%
#56 Community-Acquired Bacterial Pneumonia (CAP): Vital Signs	32,131	15.8%
#55 ECG Performed for Syncope	31,548	60.6%
#30 Timing of Prophylactic Antibiotics - Administering Physician	31,154	38.1%
#124 HIT - Adoption/Use of EHRs	26,691	3.5%
#59 Empiric Antibiotic for Community-Acquired Bacterial Pneumonia	22,677	11.1%
#1 Hemoglobin A1c Poor Control	20,277	6.5%
#2 Low Density Lipoprotein Control	19,354	6.3%

Measures where eligible professionals satisfied the reporting threshold most often—submitted for 80% of eligible instances—are displayed in Table 14. Measures in this table were submitted satisfactorily by the highest number of eligible professionals. The percent of those satisfactorily reporting these measures ranged from 49% for Measure #124 (HIT – Adoption/Use of EHRs) to 82% for Measure #58 (Community-Acquired Bacterial Pneumonia (CAP): Assessment of Mental Status). Many of these measures are typically for emergency medicine and, as stated before, this specialty will most likely have processes in place to accurately capture clinical data. Appendix Table B-15 displays the percentage of eligible professionals who satisfactorily reported each measure.

Table 14: Measures where Eligible Professionals Satisfied the Reporting Threshold Most Often (Claims-Based Individual Measures)

Measure	Number of Eligible Professionals ≥80%[a]	% Eligible Professionals Submitting ≥80%[b]
#57 Community-Acquired Bacterial Pneumonia (CAP): Assessment of Oxygen Saturation	29,327	81.02%
#54 ECG Performed for Non-Traumatic Chest Pain	29,255	77.62%
#58 Community-Acquired Bacterial Pneumonia (CAP): Assessment of Mental Status	26,431	82.09%
#56 Community-Acquired Bacterial Pneumonia (CAP): Vital Signs	25,868	80.51%
#55 ECG Performed for Syncope	25,756	81.64%
#59 Community-Acquired Bacterial Pneumonia (CAP): Empiric Antibiotic	17,233	75.99%
#30 Timing of Prophylactic Antibiotics - Administering Physician	17,224	55.29%
#124 HIT - Adoption/Use of EHRs	13,075	48.99%
#28 Aspirin at Arrival for Acute Myocardial Infarction	11,909	79.78%
#1 Diabetes Mellitus: Hemoglobin A1c Poor Control	10,086	49.74%

[a] The # of TIN/NPIs who submitted the measure on 80% or greater of eligible instances.

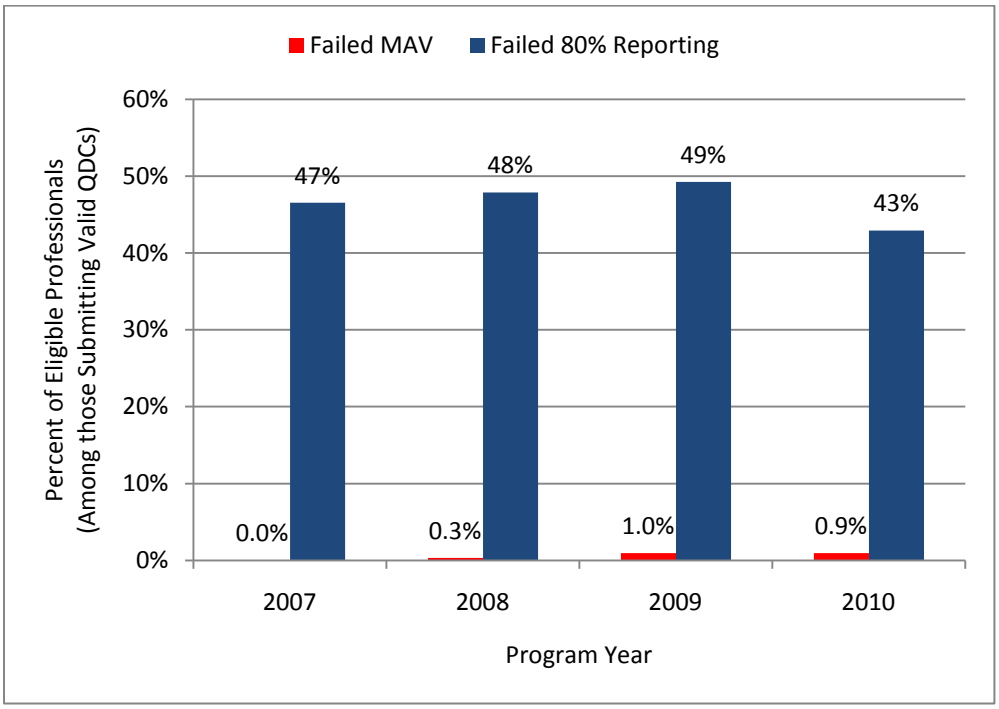
[b] The # of TIN/NPI submitting ≥80% divided by the # of TIN/NPI submitting.

Challenges to Participation and Satisfactorily Reporting

The main challenges to satisfactory participation and reporting in the Physician Quality Reporting System include: (1) failure to submit QDCs for 80% or more of eligible instances; and (2) submission of QDC errors (for example, submitting a QDC on a claim that does not have a qualifying diagnosis or the appropriate patient age, or submitting an incorrect Healthcare Common Procedure Coding System [HCPCS] code). Eligible professionals submitting data for fewer than three claims-based individual measures also had to pass the MAV process, to confirm that the eligible professional was eligible for fewer than three measures.

A common reason for not earning an incentive payment under the Physician Quality Reporting Program in 2009 was not submitting measure information for enough patients—on 80% of eligible instances. Forty-nine percent of eligible professionals submitting some valid measure data did not report on 80% of the eligible instances in 2009 (Figure 14). In the first half of 2010, this rate has shown improvement by dropping to 43% among claims submitted during that timeframe.

Figure 14: Eligible Professionals' Reporting Challenges by Physician Quality Reporting System by Program Year

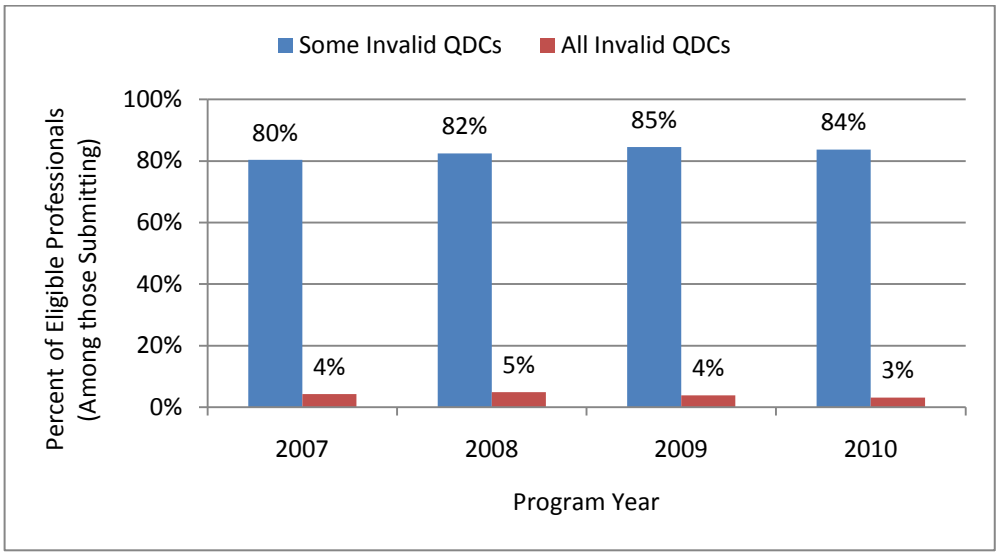


Additionally, 18% of eligible professionals submitting data through the claims-based individual measures method in the 2009 Physician Quality Reporting System were subject to MAV because they submitted data and satisfactorily reported for fewer than three measures. All but 1% of these professionals passed MAV (Figure 14).[14]

While there has been substantial growth of measures and participation by eligible professionals, the percentage of eligible professionals submitting data with QDC errors has remained relatively stable, increasing slightly by 2009 (Figure 15). Overall, 85% of eligible professionals submitting data submitted at least one instance with invalid QDC information, though only 4% submitted all data with invalid QDCs.

[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/PQRS/25_AnalysisAndPayment.asp#TopOfPage

Figure 15: Eligible Professionals' Invalid QDC Submissions in the Physician Quality Reporting System, by Program Year (Claims-Based Individual Measures)



* 2010 data shown here includes only claims processed through June 25, 2010.

CMS posts the rates of QDC errors on the Physician Quality Reporting System website.[15] These errors occur when a QDC was submitted on a claim that did not have the qualifying information (diagnosis, procedure, gender) for that measure. Since CMS does not penalize eligible professionals for submitting QDCs on ineligible claims, QDC errors do not adversely affect an eligible professional's reporting rate. However, proactive monitoring and reporting of QDC errors can provide professionals with information on the most common errors in reporting, which they can use to improve.

The most common cause of QDC errors is situations where the eligible professional reports a measure-specific QDC on a claim that does not also have the required procedure code (HCPCS). Among 43,189,698 QDC submissions for all measures in 2009, 11.9% had an incorrect HCPCS, 4.7% had an incorrect diagnosis, 2.5% had both an incorrect HCPCS and diagnosis, 2.5% had an age mismatch, 0.8% had only a QDC on the claim, 0.3% had an incorrect diagnosis and only a QDC on the claim, and 0.1% had a gender mismatch.

Though most measures had low rates of QDC errors, some measures had relatively higher rates of QDC errors. For example, 89% of QDCs reported for measure #40 (Management Following Fracture) had a mismatch between the QDC and the diagnosis on the claim. Appendix Tables B-16 through B-18 highlights measures with high rates (greater than 20%) of specific QDC errors.

[15]For 2010, 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/pqrs/).

D. Incentive Eligibility

To earn an incentive under the Physician Quality Reporting System, participating eligible professionals had to meet the criteria for satisfactory reporting applicable to the submission method and time period.

The incentive eligibility criteria for the 2009 program year, by submission method, are as follows:

- 80% individual measures method: At least 80% of eligible instances for three or more measures (or one-two, subject to MAV) for claims-based individual measure submissions or at least 80% of eligible instances for three or more measures for registry-based individual measures submissions.
- 80% measures group method: At least 80% of eligible beneficiaries have all applicable measures within the group submitted for claims-based and registry-based reporting.
- 30 consecutive measures group method: At least 30 consecutive Medicare Part B Fee for Service (FFS) patients has all applicable measures within the group submitted for claims-based reporting or at least 30 consecutive patients (may include some non-Medicare patients) has all applicable measures within the group submitted for registry measures groups reporting.

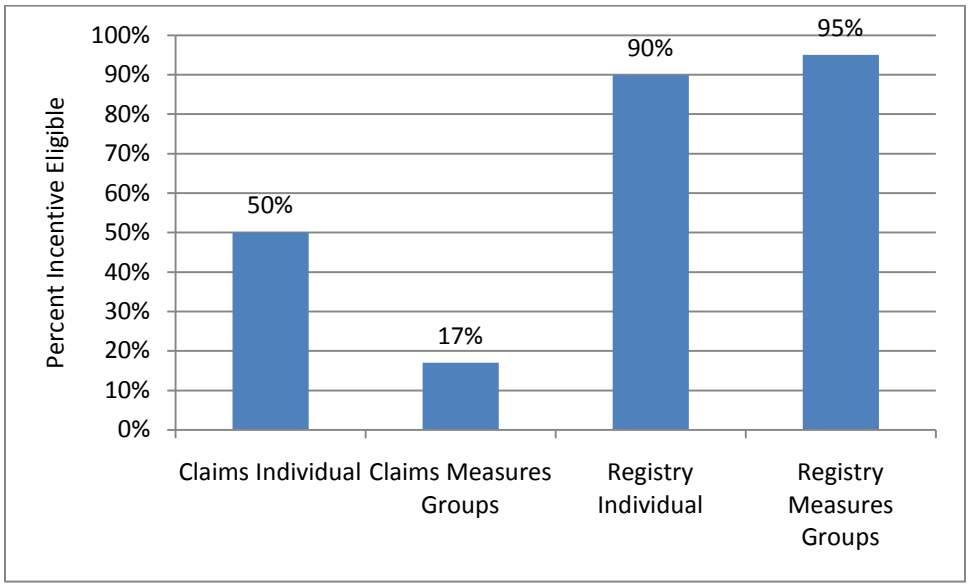
Eligible professionals meeting the requirements received a bonus payment of 2% of their estimated Medicare Part B PFS allowed charges in 2009.

Incentive Eligibility by Reporting Approach

Over half of all eligible professionals submitting a valid QDC in the Physician Quality Reporting System earned an incentive in 2009 (56.9%), slightly higher than in 2008 (55.9%) (Appendix Table B-19). While the percentage of those submitting data and earning an incentive remained stable from 2008, the *number* of eligible professionals earning an incentive increased by 39% between 2008 and 2009, with the largest percentage gain observed for those submitting via registry measures groups. The number of professionals eligible for an incentive payment under the registry measures group approach increased by 210% during this period, driven by the large increases in participation by this method.

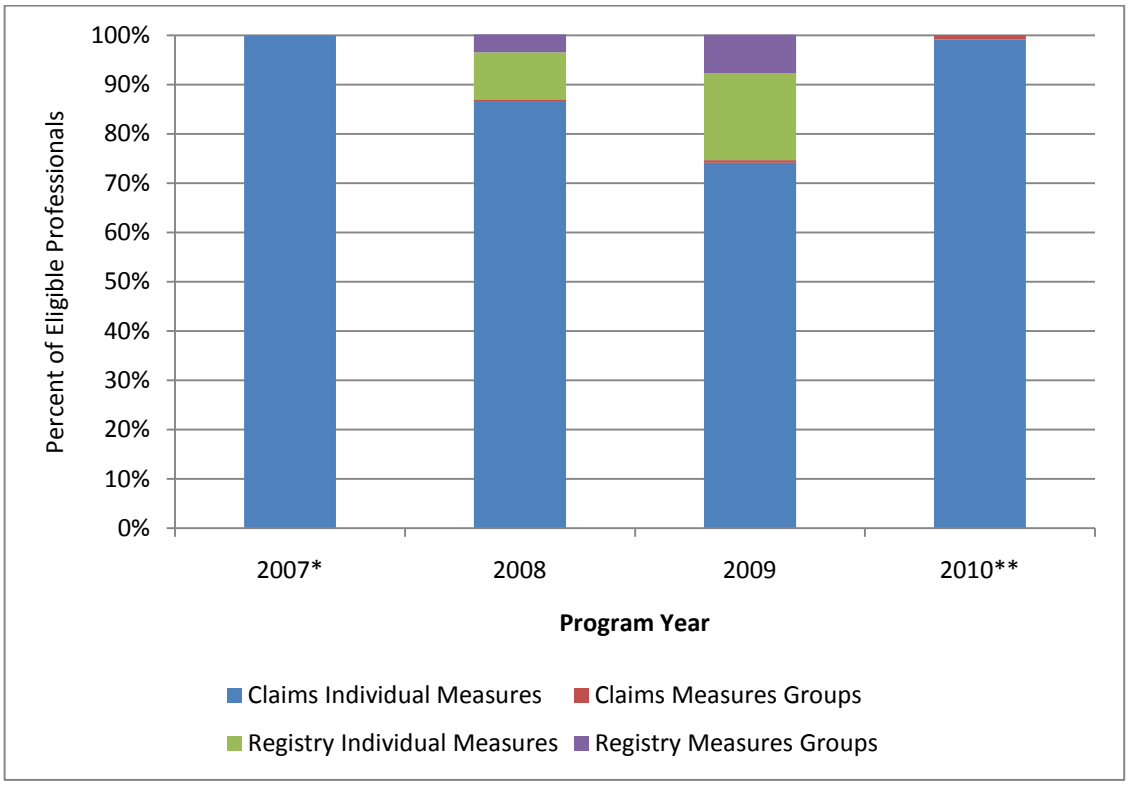
Incentive eligibility *rates* varied widely by method, and were highest among those using registry reporting and lowest among those using claims-based measures groups, as seen in Figure 16.

Figure 16: Percent of Eligible Professionals Earning a 2009 Physician Quality Reporting System Incentive, by Method



Between 2008 and 2009, the proportion of eligible professionals who earned an incentive via registries grew, while the proportion of incentives earned via claims-based measures declined (Figure 17). However, since more professionals participated via claims individual measures, more professionals earned an incentive under this method.

Figure 17: Distribution of Eligible Professionals Earning an Incentive in the Physician Quality Reporting System, by Participation Method and Program Year



* The only available method for 2007 was individual measures via claims.

** 2010 data shown here includes only claims processed through June 25, 2010. Information for Registry, GPRO, and EHR submission methods for the Physician Quality Reporting System was not available for this document; only six months of program year 2010 claims information was available.

Incentive Eligibility by Specialty

The specialties with the most eligible professionals earning an incentive follow the same patterns as with participation. Across all methods, internists and family medicine physicians had more eligible professionals earning an incentive relative to other specialties. For the claims-based individual method, emergency medicine specialists were the most common incentive earners. Appendix Tables B-20 through B-23 presents the percentage of eligible professionals from each specialty who earned an incentive by program year for each reporting method. Tables 15 through 17 display provider specialties with the most professionals earning an incentive for each reporting approach.

Among the specialties with the most incentive earners through the claims-based individual method, emergency medicine and physician assistants also had relatively high rates of incentive eligibility (Table 15).

Table 15: Top 10 Specialties Earning a 2009 Physician Quality Reporting System Incentive - Claims-Based Individual Measures

Specialty	Eligible Professionals Earning Incentive	Eligible Professionals Submitting	Percent Earning Incentive
Emergency Medicine	24,401	30,988	79%
Anesthesiology	8,070	17,488	46%
Family Practice	6,921	14,607	47%
Nurse Anesthetist	6,398	11,905	54%
Physician Assistant	5,993	8,951	67%
Internal Medicine	5,723	14,228	40%
Radiology	4,079	11,796	35%
Other Non-MD/DO	3,473	7,163	48%
Nurse Practitioner	3,351	6,110	55%
Ophthalmology	3,282	7,068	46%

As seen in Table 16, incentive eligibility rates among specialties participating in the claims-based measures groups' method were generally low (below 20%); however, orthopedic surgery and anesthesiology had relatively high proportions of eligible professionals who earned an incentive (over 30%). Each year additional measures groups have been added to allow the reporting of measures groups by more specialties.

Table 16: Top 10 Specialties Earning a 2009 Physician Quality Reporting System Incentive - Claims-Based Measures Groups

Specialty	Eligible Professionals Earning Incentive	Eligible Professionals Submitting	Percent Earning Incentive
Internal Medicine	155	1001	15%
Family Practice	110	929	12%
Orthopedic Surgery	91	246	37%
Nurse Practitioner	39	167	23%
Rheumatology	27	149	18%
Physician Assistant	24	119	20%
Other Non-MD/DO	19	145	13%
Nephrology	16	118	14%
Neurosurgery	15	59	25%
Anesthesiology	11	34	32%

The incentive eligibility rates for registry reporting were quite high among the top submitting specialties; although, other eligible professionals' incentive eligibility rates were relatively lower than among MD/DOs (Table 17).

Table 17: Top 10 Specialties Earning a 2009 Physician Quality Reporting System Incentive - Registries

Specialty	Eligible Professionals Earning Incentive	Eligible Professionals Submitting	Percent Earning Incentive
Family Practice	7,173	7,365	97%
Internal Medicine	6,338	6,472	98%
Cardiology	1,965	2,007	98%
Nurse Practitioner	1,526	1,622	94%
Physician Assistant	1,169	1,243	94%
Nephrology	1,011	1,033	98%
Other Non-MD/DO	1,003	1,063	94%
OB/GYN	920	973	95%
Orthopedic Surgery	881	916	96%
General Surgery	682	709	96%

E. Clinical Performance Rates

Although Physician Quality Reporting System incentive payments are currently based on reporting outcomes, an overarching goal of the program is to improve clinical measure performance rates and patient outcomes.

This section of the report focuses on clinical performance rates and trends.[16] Average measure performance across three years for Physician Quality Reporting System measures is reported in Appendix Table B-24. The ability to draw inferences from comparisons across years is limited due to the large increase in reporting between 2007 and 2009 as well as the expansion and discontinuation of measures in the program. However, broad trends are evident from the data in Appendix Table B-24.

Overall, among the 55 common measures reported between 2007 and 2009, clinical performance rates increased by an average of 3.1% during this period. The median percentage point change for all measures during this period was an increase of 1.3 percentage points as most measures (58%) showed improvement during this period. The largest decreases in clinical performance

[16] The measure performance rate is calculated as the number of times the eligible professional submitted a valid QDC indicating positive performance, divided by the number of instances they submitted QDCs (excluding instances where an exclusion QDC was submitted), and multiplied by 100 to create a percentage. Performance rate calculations for 2007 and 2008 were updated to reflect requirements for the 2009 Physician Quality Reporting Program.

rates during this period were observed for measures with fewer than 500 eligible professionals reporting the measure.

Tables 18 and 19 display the measures with the largest percentage point decline and improvement between 2007 and 2009 among measures reported by more than 500 eligible professionals. Many of the large changes over time may be driven by the inclusion of registry data and the expansion of professionals participating in the Physician Quality Reporting System. For example, in 2009, Measure #7 changed to a measure that could only be submitted by a registry. The performance calculation for Measure #7 in claims may have differed from the registry data which could reflect a significant change in the performance rate. The other measures in Table 18 had a large increase in the number of eligible professionals submitting these measures which could result in a decrease in the performance rate. The increased number of eligible professionals submitting these measures could be due to the addition of registry submissions. The drop in performance could also indicate measures are reported by eligible professionals when the measure may not truly be applicable to their practice so they may reach the requirements of three measures to report. As more measures have been added to the program, eligible professionals may start reporting on measures that are more applicable to their practice. The measures with the largest percentage improvement shown in Table 19 could be affected by the inclusion of registry performance data. Registries, in some cases, have better collection methods to accurately reflect the clinical data needed to calculate the measures. Appendix Table B-24 shows that while guideline concordant care occurred during a majority of care instances, measure #47, Advance Care Plan, was consistently reported at performance rates below 50%.

Among performance measures reported in 2008 and 2009 (N=99 measures) the average measure showed improvement in the performance rate of 10.6%, with a median percentage point increase of 0.6 percentage points. Just over half of all measures (55%) showed improved performance.

Table 18: Measures with Largest Percentage Point Decrease in Performance Rate 2007-2009, Claims- and Registry-Based Individual Measures

Measure	2007 Performance Rate (%)	2009 Performance Rate (%)	Percentage Point Change 2007 – 2009
#7 Beta-blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction (MI)	91	61	-30
#49 Characterization of UI in Women Aged 65 Years and Older	96	69	-27
#51 COPD: Spirometry Evaluation	80	54	-26
#48 Assessment of Presence or Absence of UI in Women Aged 65 Years and Older	82	57	-24
#39 Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older	80	57	-23

Note: This table includes measure performance among eligible professionals submitting valid measures, regardless of whether they met the 80% satisfactory reporting requirements.

Table 19: Measures with Largest Percentage Point Improvement in Performance Rate 2007-2009, Claims- and Registry-Based Individual Measures

Measure	2007 Performance Rate (%)	2009 Performance Rate (%)	Percentage Point Improvement 2007 - 2009
#19 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	52	93	+41
#22 Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	54	95	+40
#35 Stroke and Stroke Rehabilitation: Screening for Dysphagia	43	77	+33
#45 Perioperative Care: Discontinuation of Prophylactic Antibiotics	68	100	+32
#8 Heart Failure: Beta-blocker Therapy for LVSD	64	95	+31

Note: This table includes measure performance among eligible professionals submitting valid measures, regardless of whether they met the 80% satisfactory reporting requirements.

For some measures, improvement in measure performance over time is limited by measure performance that is 'topped out.' In other words, if for eligible professionals reporting a measure, performance is at or near 100%, the ability to improve performance is limited. Tables 20 – 22 display the measures with the highest mean clinical performance rates in each year of the program.

Table 20: Top 10 Measures with Highest Mean Performance Rates, 2009 (Claims and Registry Individual Measures)

Measure	Mean Performance Rate (%)	#Eligible Professionals Submitting
#165 Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	100.00%	11
#166 Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)	100.00%	4
#167 Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency	100.00%	4
#45 Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	99.48%	1,227
#124 HIT - Adoption/Use of EHRs	99.15%	37,821
#72 Chemotherapy for Stage III Colon Cancer Patients	98.83%	1,273
#43 Use of IMA in CABG Surgery	97.96%	1,521
#68 Myelodysplastic Syndrome: Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	97.69%	1,269
#100 Colorectal Cancer Patients with a pT and pN Category and Histologic Grade	97.46%	4,202
#131 Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up	97.43%	5,533
#139 Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement	97.42%	3,117

* Note: This table includes measure performance among eligible professionals submitting valid measures, regardless of whether they met the 80% satisfactory reporting requirements.

Table 21: Top 10 Measures with Highest Mean Performance Rates, 2008 (Claims and Registry-Based Individual Measures)

Measure	Mean Performance Rate (%)	Number Eligible Professionals Submitting
#125 HIT - Adoption/Use of e-Prescribing	99.98%	4,537
#73 Plan for Chemotherapy Documented Before Chemotherapy Administered	99.14%	937
#131 Pain Assessment Prior to Initiation of Patient Treatment	98.07%	3,545
#18 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	96.80%	7,137
#132 Patient Co-Development of Treatment Plan/Plan of Care	96.44%	3,255
#55 ECG Performed for Syncope	95.33%	28,456
#100 Colorectal Cancer Patients with a pT and pN Category and Histologic Grade	95.25%	3,877
#14 AMD: Dilated Macular Examination	95.01%	8,803
#43 Use of IMA in CABG Surgery	94.99%	1,284
#59 Empiric Antibiotic for Community-Acquired Bacterial Pneumonia	75.59%	19,950

Note: This table includes measure performance among eligible professionals submitting valid measures, regardless of whether they met the 80% satisfactory reporting requirements. Measure 124, Adoption/Use of EHRs, as defined, yields an overall performance rate of 100% and is therefore not reported in this table.

Table 22: Top 10 Measures with Highest Mean Performance Rates, 2007 (Claims-Based Individual Measures)

Topic Measure	Mean Performance Rate	Number Eligible Professionals Submitting
#65 Upper Respiratory Infection: Appropriate Treatment for Children	100.00%	1
#16 Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation	99.66%	3,218
#73 Plan for Chemotherapy Documented Before Chemotherapy Administered	99.01%	1,561
#17 Cataracts: Pre-Surgical Dilated Fundus Evaluation	98.71%	2,973
#25 Melanoma: Patient Medical History	97.66%	2,428
#18 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	97.41%	6,262
#27 Melanoma: Counseling on Self-Examination	97.07%	2,360
#64 Asthma Assessment	96.89%	80
#49 Characterization of UI in Women Aged 65 Years and Older	96.43%	1,221
#26 Melanoma: Complete Physical Skin Examination	95.43%	2,407

Note: This table includes measure performance among eligible professionals submitting valid measures, regardless of whether they met the 80% satisfactory reporting requirements.

Some measures show particularly high rates of performance across all eligible professionals. Table 23 display measures where at least 90 percent of all eligible professionals achieve performance at or above 90% in 2009. Appendix Table B-25 displays the percent of eligible professionals with performance rates at or above 90% for all measures.

Table 23: 2009 Physician Quality Reporting System Measures with at Least 90% of Submitting Eligible Professionals Achieving at Least 90% Performance Rate (Claims Individual Measures)

Topic Measure	Percent of TIN/NPIs with >=90% Performance[a]
#180 Rheumatoid Arthritis (RA): Glucocorticoid Management	98.34%
#146 Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening*	98.16%
#139 Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement	96.97%
#43 Use of IMA in CABG Surgery	96.79%
#45 Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	96.17%
#18 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	95.84%
#131 Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up	95.59%
#14 Age-Related Macular Degeneration: Dilated Macular Examination	93.58%
#20 Perioperative Care: Timing of Antibiotic Prophylaxis - Ordering Physician	93.43%
#100 Colorectal Cancer Patients with a pT and pN Category and Histologic Grade	93.00%
#156 Oncology: Radiation Dose Limits to Normal Tissues	92.80%
#137 Melanoma: Continuity of Care - Recall System	92.14%
#58 Assessment of Mental Status for Community-Acquired Bacterial Pneumonia	91.51%
#136 Melanoma: Follow-Up Aspects of Care	91.29%
#122 Chronic Kidney Disease (CKD): Blood Pressure Management	91.00%
#141 Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	90.89%
#12 Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	90.53%
#23 Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis	90.40%
#49 Characterization of UI in Women Aged 65 Years and Older	90.35%
#22 Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	90.31%

Note: This table includes measure performance among eligible professionals submitting valid measures, regardless of whether they met the 80% satisfactory reporting requirements. Measure 124, Adoption/Use of EHRs, as defined, yields an overall performance rate of 100% and is therefore not reported in this table.

[a] The percentage of TIN/NPIs who have a performance rate of 90% or higher

[b] This is an inverse measure, therefore the percentage represents the percentage of TIN/NPIs with performance rates of 10% or lower.

IV. ELECTRONIC PRESCRIBING (eRx) INCENTIVE PROGRAM

A. Background

Program Description

Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. Law 110-275, July 15, 2008) authorized a new and separate incentive program—the Electronic Prescribing (eRx) Incentive Program—for eligible professionals who are successful electronic prescribers, as described under section 1848(m)(3)(B) of the Social Security Act. The incentive program began on January 1, 2009, and is separate from the Physician Quality Reporting System.

Under the 2009 eRx Incentive Program, participants report their use of a qualified electronic prescribing system during an eligible visit with a Medicare beneficiary. A qualified electronic prescribing system is one that is capable of all of the following:[17]

- Generate a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBMs) if available
- Select medications, print prescriptions, electronically transmit prescriptions, and conduct all alerts
- Provide information related to lower cost, therapeutically appropriate alternatives (if any). (The availability of an electronic prescribing system to receive tiered formulary information, if available, would meet this requirement for 2009)
- Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available)
- The system must employ, for the capabilities listed, the electronic prescribing standards adopted by the Secretary for Part D by virtue of the 2003 Medicare Modernization Act (MMA).

The eRx Incentive Program has one quality measure that professionals report to demonstrate use of such a system. In 2009, this was the same as the 2008 Physician Quality Reporting System measure (measure #125: HIT-Adoption/Use of E-Prescribing). To participate in the eRx Incentive Program in 2009, eligible professionals had to report this measure on eligible Medicare Part B claims. Individual eligible professionals do not need to register to participate in the eRx Incentive Program.

To participate in 2009, eligible professionals reported a valid quality-data code (QDC), also known as a G-code, for the measure on an eligible instance. Eligible instances are defined as claims having one of a specific set of CPT or HCPCS codes indicating a professional visit such

[17] The eRx measure specification can be found at http://www.cms.gov/ERxIncentive on the 2009 eRx Incentive Program page.

as evaluation and management services.[18] Valid QDCs in 2009 included one 'performance met code' and two 'exclusion' codes:

- **G8443:** All prescriptions created during the encounter were generated using a qualified e-prescribing system
- **G8446:** Eligible professional does have access to a qualified e-prescribing system. Some or all prescriptions generated during the encounter were printed or phoned in as required by state or federal law or regulations, patient request, or pharmacy system being unable to receive electronic transmission; OR because they were for narcotics or other controlled substances
- **G8445:** No prescriptions were generated during the encounter. Eligible professional does have access to a qualified e-prescribing system

To earn the incentive payment for the 2009 eRx Incentive Program, an individual eligible professional had to meet two criteria:

1. **Incentive eligibility threshold.** At least 10% of a successful electronic prescriber's Medicare Part B covered services must have been made up of codes that appear in the eRx Incentive Program denominator
2. **Submitting successfully.** Eligible professionals had to report the eRx Incentive Program measure in at least 50% of the cases in which the measure was reportable (eligible instances) by the eligible professional during 2009

Eligible professionals who do not meet both criteria are not eligible for an incentive payment. Incentive payments were based on 2% of the total estimated Medicare Part B allowed charges for covered professional (PFS) services furnished by the eligible professional during the reporting period.

[18] 2009 denominator codes (CPT/HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, G0101, G0108, G0109

Program Evolution

After the first year, the eRx Incentive program was expanded in 2010 to further support participation and successful reporting, as shown in Table 24.

Table 24: eRx Incentive Program Characteristics and Changes, 2008-2010

	2008 *	2009	2010
Incentive Payment	1.5%	2%	2%
Reporting Periods	January 1 – December 31 July 1 – December 31	January 1 – December 31	January 1 – December 31
Reporting Mechanisms	Claims, Registry	Claims	Claims, Registry**, EHR**
Individual or GPRO	Individual Eligible Professionals only	Individual Eligible Professionals only	Individual Eligible Professionals, Group Practices (GPRO)**
Quality-Data Code(s)	G8433, G8445, G8446	G8433, G8445, G8446	G8553
Successful Reporting	80% of eligible instances on 3 or more measures; OR 1 - 2 subject to MAV	50% of eligible instances	At least 25 eligible events for individual Eligible Professionals At least 2500 eligible events for GPROs
Incentive Eligibility Threshold	None	10% of eligible instances	10% of eligible instances

* In 2008 the electronic prescribing quality measure was a measure under the Physician Quality Reporting System (#125).

** Only registries, EHR vendors, and GPROs qualified for the 2010 Physician Quality Reporting System may participate.

- The QDCs for reporting on claims were simplified to one code: **G8553-**At least one prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system.
- The denominator codes identifying eligible visits for reporting were expanded to include home health, domiciliary visits, nursing home, and psychiatric care.[19]
- The reporting methods expanded from claims only to include qualified registry and EHR methods. Registries and EHR vendors that qualified for the 2010 Physician

[19] 2010 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, G0109

Quality Reporting System and had the capacity to report the eRx Incentive Program measure could participate.

- The program added a Group Practice Reporting Option (GPRO), available to groups of providers also participating in the 2010 Physician Quality Reporting System (participation in the eRx Incentive Program was not required of groups of providers participating in the GPRO). To be a successful electronic prescriber, the group practice must report the eRx Incentive Program measure at least 2,500 times during the reporting period. Groups using this option could report through claims, registry or EHR methods.

Individual participants had to report on 25 eligible instances, rather than 50% of all eligible instances, to be a successful submitter.

Overall, 669,691 professionals (TIN/NPIs) were eligible to participate in the eRx Incentive Program in 2009 based on eligible claims, compared to 644,551 in 2008. In the first half of 2010, there were 591,252 professionals eligible for the eRx Incentive Program. Please note, the 2010 numbers available for this report contained only 6 months of data whereas the 2009 numbers encompassed an entire program year; the 2010 numbers are expected to increase when data for the entire program year are available.

B. Incentive Payments

In 2009, $148,007,815.60 in incentive payments (39% of the total paid in both the Physician Quality Reporting System and eRx Incentive Programs) were paid to 48,354 eligible professionals representing 10,207 practices (Table 25). The average incentive payment was $3,060.92 per eligible professional and $14,500.62 per practice. Based on claims processed by CMS in the first half of 2010, the mean incentive amount would be $1,743.38 per eligible professional, and $4,804.29 per TIN.

Table 25: 2009 and 2010 eRx Incentive Payments

	2009	2010*
Eligible professional mean incentive payment (TIN/NPI)	$3,060.92 (n=48,354)	$1,743.38 (n=31,159)
Practice mean incentive payment (TIN)	$14,500.62 (n=10,207)	$4,804.29 (n=11,307)
Total Incentives Distributed by Medicare	**$148,007,815.60**	**$56,969,516.88**

* 2010 data shown here includes only claims processed through June 25, 2010.

Appendix Table C-1 presents the distribution of payments in 2009. The majority of 2009 incentive payments were paid to the top participating specialties—cardiology, ophthalmology, internal medicine, family practice, oncology/hematology, and orthopedic surgery. Appendix Table C-2 shows the average potential incentive by specialty (based on 2% of total Medicare Part B PFS allowed charges among eligible professionals), compared to the participation rate. Some specialties with relatively high potential incentive payments but relatively low participation include specialties that are not likely to have at least 10% of their Medicare Part B PFS allowed charges comprised of codes included in the denominator of the electronic prescribing measure.

C. Participation

How to Participate

With one measure and one reporting period (January 1 through December 31), participating in the 2009 eRx Incentive Program was relatively straightforward. Eligible professionals did not have to enroll or file any intent to participate in the eRx Incentive Program. In 2009, the mechanism for reporting data on the electronic prescribing quality measure was solely claims based: individual eligible professionals had only to identify eligible Part B physician services (visits) and report one of three valid QDCs on Part B claims for these services.

In 2010, eligible professionals could report using the claims-based method to report the one QDC for 2010—indicating at least one prescription was generated using a qualified electronic prescribing system—as well as participate by reporting data on the electronic prescribing quality measure through qualified registries or EHR vendors. As of June 2010, there were 50 qualified registries and 5 qualified EHR vendors submitting data for the 2010 eRx Incentive Program.[20]

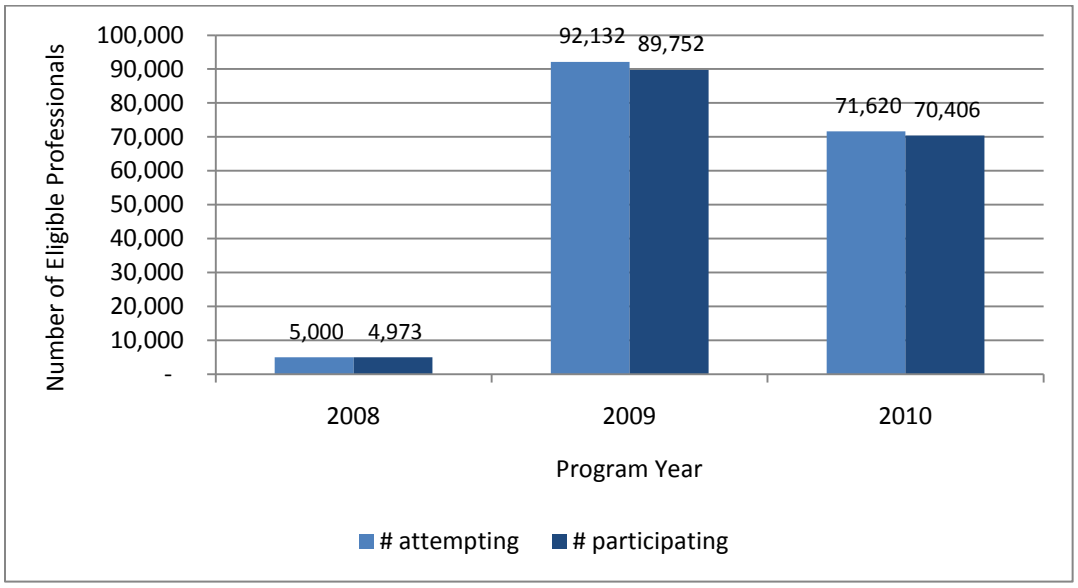
In 2009, eligible professionals had to report valid QDCs for at least 50% of their eligible visits. In 2010, this requirement was revised to require reporting on a minimum of 25 eligible instances.

Participation Findings

Overall, 89,752 eligible professionals (13.4% of those eligible) participated in the 2009 eRx Incentive Program by submitting at least one valid QDC (Figure 18). This represented a large increase from 2008 under the Physician Quality Reporting System, when only 4,973 eligible professionals (0.8% of those eligible) submitted the eRx measure.

[20] http://www.cms.gov/ERxIncentive/08_Alternative%20Reporting%20Mechanism.asp#TopOfPage

Figure 18: Number of Eligible Professionals Participating in the eRx Incentive Program Through Claims, 2008-2010*



* 2010 results reflect claims processed by June 25, 2010. Attempting refers to any submission of an eRx QDC; participating only counts valid QDC submissions.

Although results for 2010 are incomplete, by June 2010, 70,406 eligible professionals (11.9% of those eligible to participate) had already submitted data for the eRx Incentive Program measure through claims. (Results for registry and EHR electronic prescribing submissions were not yet available at the time this document was created.)

MD/DO practitioners were more likely than other eligible professionals to participate in the eRx Incentive Program in 2009 (Table 26). Among eligible professionals, about one in seven (15.2%) submitted a QDC on a claim, while about one in ten 'Other Eligible Professional' practitioners submitted a QDC on a claim (9.5%).

Table 26: 2009 eRx Incentive Program Participation among MD/DOs and Other Eligible Professionals

Type of professional	Number Eligible	Number Participating	Percent Participating
MD/DO	458,910	69,835	15.22%
Other Eligible Professionals	209,865	19,868	9.47%
Total	669,691	89,752	13.40%

Certain specialties were more likely to participate in the 2009 eRx Incentive Program than others (Table 27). Appendix Table C-3 presents results for all specialties.[21] Family practice and internal

[21] Note: All results by specialty are reported at the TIN/NPI; there may be duplicate counts for NPI (eligible professionals) billing under more than one TIN. Specialty is self-designated and identified from the National Plan and Provider Enumeration System (NPPES).

medicine had the largest number of eligible and participating professionals, followed by nurse practitioner, cardiology, and ophthalmology. These specialties see a high number of patients where the eligible professional is prescribing a high volume of drugs. Specialties with particularly high rates of participation included ophthalmology and cardiology, as well as rheumatology, urology, and oncology/hematology.

Table 27: Specialties with the Highest Participation in 2009 eRx Incentive Program

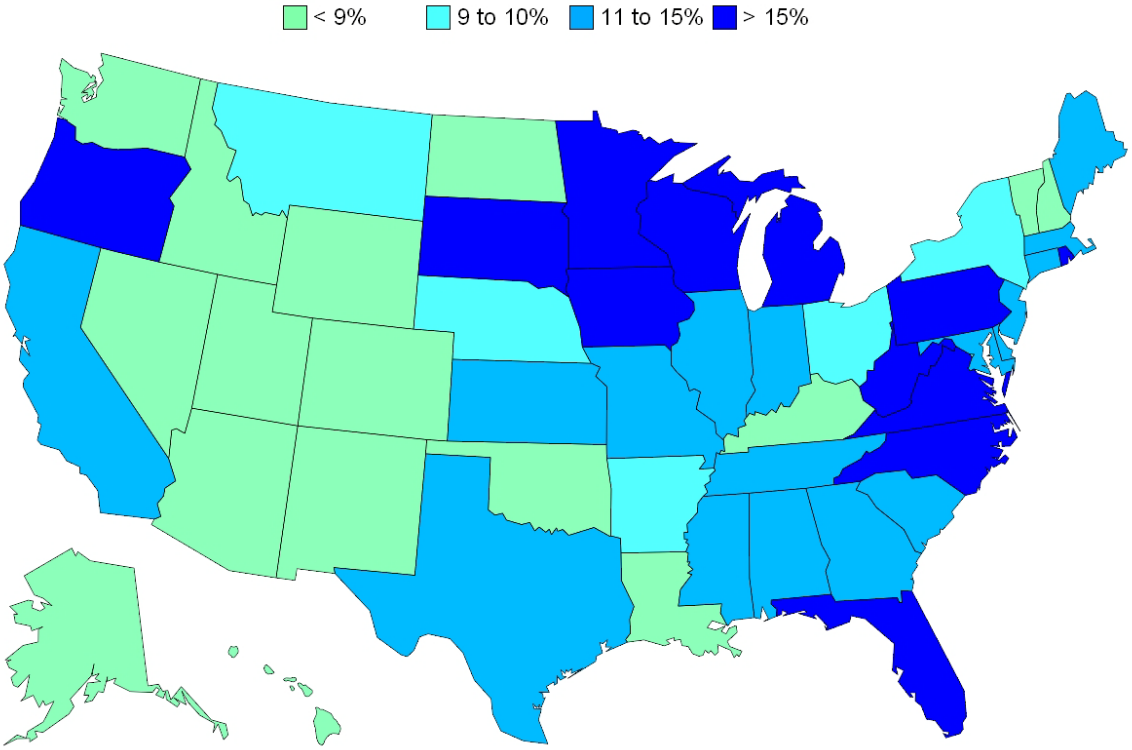
Specialty	Number Eligible	Number Participating	Percent Participating
Specialties with highest numbers			
Family Practice	81,998	15,753	19.2%
Internal Medicine	76,929	13,864	18.0%
Nurse Practitioner	35,622	6,202	17.4%
Cardiology	22,142	6,132	27.7%
Ophthalmology	18,930	5,609	29.6%
Specialties with highest rates			
Ophthalmology	18,930	5,609	29.6%
Cardiology	22,142	6,132	27.7%
Rheumatology	4,197	962	22.9%
Urology	8,953	1,886	21.1%
Oncology/Hematology	10,529	2,144	20.4%

There was a strong correlation between the number of eligible beneficiaries seen by an eligible professional and the likelihood of submitting eRx Incentive Program data in 2009 (Appendix Table C-4). Eligible professionals with more than 200 eligible beneficiaries were nearly five times more likely to submit an eRx Incentive Program QDC than eligible professionals who saw between 6 and 25 eligible beneficiaries. Hence, those eligible professionals who would not meet the 10% incentive eligibility threshold were less likely to participate in the eRx Incentive Program.

Participation in the 2009 eRx Incentive Program varied by location. The number of eligible professionals participating in the eRx Incentive Program in a state ranged from 60 in Alaska[22] (3.8% of those eligible) to 6,430 in California (11.6% of those eligible) (Appendix Table C-5). It should also be noted that some state law limitations on electronic prescribing may affect eligible professionals from participating in the eRx Incentive Program. Figure 19 presents the distribution of participation rates across the country.

[22] Two eligible professionals in the Virgin Islands, and 36 in Puerto Rico, also participated.

Figure 19: 2009 eRx Incentive Program Participation Rates by State



Successes and Challenges in Participation

In 2009, 97% (89,752) of 92,132 eligible professionals submitted at least one valid QDC. The remainder submitted a valid QDC numerator code on a claim that was not denominator eligible. For the 2010 program year, as of June 2010, out of the 71,620 eligible professionals attempting to submit, over 98% submitted at least one valid QDC.

Among the eligible professionals submitting valid QDC codes, over half (50,924) were "successful electronic prescribers" under the eRx Incentive Program, meaning that they submitted valid QDCs on at least 50% of eligible visits. The remaining 45% failed to report QDCs on enough eligible visits. For the program year 2010, as of June 2010, 31,336 eligible professionals (45%) had reported successfully through claims, by reporting on at least 25 eligible instances; this rate is expected to rise over the whole year as participants have more eligible instances on which to report. In addition, it is possible that, as of June 2010, many eligible professionals had not yet started their eRx submissions.

The same five MD/DO specialties with highest numbers of professionals participating (family practice, internal medicine, cardiology, ophthalmology, and orthopedic surgery) in the 2009 Physician Quality Reporting System were also the specialties with the highest numbers of eligible professionals successfully reporting under the 2009 eRx Incentive Program. Rates of successful reporting among those eligible professionals participating varied widely from 38% to over 90% (Appendix Table C-3). Among specialties with over 100 eligible professionals participating, ophthalmology had the highest successful reporting rate (71%).

D. Incentive Eligibility

To qualify for an incentive payment under the 2009 eRx Incentive Program, an eligible professional must have been a successful electronic prescriber *and* their charges for eligible visits for the program must make up at least 10% of their overall Part B PFS allowed charges. In 2009, to submit successfully, eligible professionals had to report valid QDCs for at least 50% of their eligible visits. In 2010, this requirement was revised to report on at least 25 eligible instances.

In 2009, 85,540 eligible professionals out of 89,572 submitting (95%) met the 10% threshold for eligibility (Appendix Table C-6). There are specialties where many eligible professionals did not meet the threshold for participation. These specialties may provide relatively few evaluation and management visits and therefore could not reach the 10% threshold for incentive eligibility.

Overall 48,254 eligible professionals were both successful electronic prescribers and met the 10% threshold and qualified for an eRx Incentive Program payment. This represents 54% of those participating (Appendix Table C-3). The rate of incentive eligibility ranged from less than 40% for eight specialties to over 60% for 3 specialties.

Table 28 presents the specialties with the highest number of eligible professionals earning an incentive payment in 2009, as well as the specialties with the highest rates of incentive eligibility among those submitting. Ophthalmology and nurse practitioner were among the specialties with the largest number of participants who were incentive eligible and who had the highest rates of incentive eligibility.

Table 28: Specialties with the Most Professionals Earning an Incentive in 2009 eRx Incentive Program

Specialty	Number Submitting	Number Incentive Eligible	Percent Incentive Eligible
Specialties with highest numbers			
Family Practice	15,753	8,256	52.4%
Internal Medicine	13,864	7,320	52.8%
Ophthalmology	5,609	3,961	70.6%
Nurse Practitioner	6,202	3,888	62.7%
Cardiology	6,132	3,334	54.4%
Specialties with highest rates			
Ophthalmology	5,609	3,961	70.6%
Oncology/Hematology	2,144	1,375	64.1%
Nurse Practitioner	6,202	3,888	62.7%
Registered Nurse	174	108	62.1%
Pediatrics	242	148	61.2%

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 distributed separately from the incentive payment, CMS strives to distribute feedback reports as closely as possible to delivery of the incentive payment. Feedback reports availability does not depend on earning an incentive payment. Instead, TIN-level feedback reports are available for every TIN under which at least one eligible professional (identified by his or her NPI) submits Medicare Part B PFS claims with at least one QDC for either a Physician Quality Reporting System measure or the eRx Incentive Program measure. NPI-level feedback reports are also available for an individual eligible professional (as identified by his or her NPI) participating in the Physician Quality Reporting System or the eRx Incentive Program.

The 2009 Physician Quality Reporting System and the eRx Incentive Program feedback reports became available in November and early December of 2010.

B. Accessing Feedback Reports

Feedback reports can be accessed through two different processes: (1) TIN-level feedback reports from the Physician and Other Health Care Professionals Quality Reporting Portal; (2) NPI-level feedback reports through the Part A and B Medicare Administrative Contractors (A/B MACs and carriers). The first process allows for a secure means required to provide the TIN-level feedback. The second process was created to ease the availability of the reports for individual professionals. Feedback reports for multiple program years are available via both of these processes.

TIN-Level Feedback Report Access

2009 TIN-level feedback reports are accessible to TIN representatives (i.e. not individual eligible professionals); TINs have discretion whether to distribute among those individual eligible professionals. Eligible professionals who are solo practitioners have access to TIN-level feedback reports.

2009 TIN-level feedback reports are available through the Physician and Other Health Care Professionals Quality Reporting Portal. To access these reports, the TIN representative must create an Individuals Authorized Access to the CMS Computer Services (IACS) account, which is required 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 accessible only to persons specifically authorized by that TIN. For further information regarding this process, see the Physician Quality Reporting System website on the Educational Resources page.

NPI-Level Feedback Report Access

2009 NPI-level feedback reports are accessible to individual eligible professionals. Individual eligible professionals need to contact their A/B MAC or carrier to request the NPI-level feedback

report, which will be e-mailed. For further information regarding this process, see the Educational Resources page of the Physician Quality Reporting System website.

C. Report Content

Each year CMS received input from eligible professionals and specialty societies on the layout and content of the feedback reports. Based on this input, CMS updated the feedback reports each year. Additionally, as the program expanded, these reports accommodated the new reporting mechanisms established for each year.

The 2009 Physician Quality Reporting System feedback reports are packaged at the TIN-level, with individual-level reporting (or NPI-level) and performance information for each eligible professional who reported at least one quality-data code (QDC) on a claim submitted under that TIN for services furnished during the reporting period. Reports include information on reporting rates, clinical performance, and incentives earned by individual professionals, with summary information on reporting success and incentives earned at the practice (TIN) level. Reports also include information on the measure-applicability validation (MAV) process and any impact it had on the eligible professional's incentive eligibility. Physician Quality Reporting System and eRx Incentive Program participants will not receive claim-level details in the feedback reports.

For both the PQRS and eRx Incentive Programs, all Medicare Part B claims submitted and all registry data received for services furnished from January 1, 2009 – December 31, 2009 (for the 12-month reporting period) and for services furnished from July 1, 2009 – December 31, 2009 (for the 6-month reporting period) were analyzed to determine whether the eligible professional earned an incentive payment according to the specific reporting thresholds of each program.

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 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. Three Support Desks

1. The External User Services Help Desk provided assistance with obtaining an IACS Security Login for access to the Physician Quality Reporting System Portal. IACS (Individuals Authorized Access to CMS Computer Systems) had two levels of accounts for the Physician Quality Reporting System: Individual Practitioner for professionals who submitted claims and received reimbursement under a personal Social Security Number, and Organizations, for professionals who submitted claims and received reimbursement under a Tax Identification Number (TIN). The EUS Help Desk assisted with vetting the Organization's Security Official, who is the first person in the group to register for an account. EUS received and approved IRS documents from the Organization to verify the employment status of the person seeking Security Official status. Then an End User would register, and only that End User would have access to the Physician Quality Reporting System Portal to retrieve the Feedback Report. Once the initial accounts were setup, users need to add the Physician Quality Reporting System user role. 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. 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) system.

2. The CMS A/B MAC and Carrier Provider Contact Centers provide normal Medicare Enrollment and claims submission support. This now includes the responsibility of disbursing the Physician Quality Reporting System payments to eligible professionals who earned incentives, paid at the TIN level. They answer questions related to whether a payment was disbursed, understanding the Remittance Advice, or explaining any offsets or adjustments. In 2009, the A/B MAC and Carriers were also tasked with accepting requests for individual NPI-level feedback reports through the Alternative Feedback Report Request Process. This enabled individuals, whether solo practitioners, or those within an Organization, to request the NPI-level Report be sent to them via email instead of via the Physician Quality Reporting System Portal. This alternative was implemented in response to some difficulties eligible professionals were having obtaining their IACS login.

3. The QualityNet Help Desk consisted of one level of support initially, known as Tier I, which consisted of a team dedicated to issues relative to the Physician Quality Reporting System team. 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 receive an incentive and needed information in addition to their feedback report. Tier II also handles requests for claims level data for professionals who did not earn an incentive. In 2010, a third tier was implemented to focus on providing data for both individual measure reporting as well as measures groups reporting, so that professionals could better understand their feedback reports and use that knowledge to be more successful in future years. 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. Professionals will still need to contact the EUS Help Desk for issues related to Medicare Enrollment and the PECOS system.

Eligible professionals are encouraged to utilize the services of 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: EUSSupport@cgi.com

2. CMS A/B MAC and Carrier Provider Contact Centers:
   To get a list of Contact Centers, see the "Provider Call Center Toll-Free Numbers Directory" by clicking on the following link http://www.cms.gov/MLNGenInfo/ and scrolling below to the "Downloads" section.

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

VIII. CONCLUSION

The Physician Quality Reporting System and the eRx Incentive Program have grown over time and were expanded further in 2010 to promote participation and reporting success. For example, Physician Quality Reporting System has more measures available on which to report as well as more reporting mechanisms (EHRs or GPRO). For the eRx Incentive Program, the change in reporting criteria from 50% of eligible cases in 2009 to reporting 25 eligible cases in 2010 could improve the rate of successful eRx Incentive Program reporting. While it is hard to draw conclusions from partial year results, it is encouraging that, based on claims filed by mid-year, the number of participants in both the 2010 Physician Quality Reporting System and the 2010 eRx Incentive Program is greater than half of the total from 2009. In addition, clinical performance rates for the Physician Quality Reporting System have shown improvement over time, as illustrated throughout the performance sections above.

There are further changes in 2011 that should impact reporting experience in these programs:

- Reducing the requirement for cases submitted from 80% to 50% in the Physician Quality Reporting System
- Addition of 20 new measures and one new measures group in the Physician Quality Reporting System
- An increase of 10 measures for EHR reporting in the Physician Quality Reporting System
- The addition of GPRO II reporting mechanisms for smaller groups under both programs
- Reporting requirement for avoiding the 2012 eRx payment adjustment

In addition, the Affordable Care Act mandated a number of changes to the reporting programs that will shape future experience. There will be a reduction of the bonus incentive percentage from 2% to 1% for both programs in 2011. Further, future years will begin to impose payment adjustments for eligible professionals who do not satisfactory report Physician Quality Reporting System data (starting in 2015) or who are not successful electronic prescribers through the eRx Incentive Program (starting in 2012). The Affordable Care Act also mandated allowing eligible professionals to qualify for an additional 0.5% incentive if they satisfactorily report Physician Quality Reporting System measures and participate in a Maintenance of Certification program for a year and successfully submits a Maintenance of Certification program practice assessment. Overall, the Physician Quality Reporting System and the eRx Incentive Program have continuously expanded to ensure participation and reporting success to prepare for the eventual payment adjustments associated with these important programs.