2012 Reporting Experience

Including Trends (2007-2013)

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

March 14, 2014

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I. EXECUTIVE SUMMARY

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

This report summarizes the reporting experience of eligible professionals in these programs in 2012, historical trends, and preliminary results for the 2013 program year. Unless otherwise noted, all tables and figures present 2012 data. Findings reported at the practice level include both eligible professionals participating individually, summarized at the practice level, as well as group practices that participated through a group practice reporting option (GPRO). For the Physician Quality Reporting System only, the group practice results also include eligible professionals participating as part of an Accountable Care Organization (ACO) under the Medicare Shared Savings Program (MSSP) or Pioneer ACO Model.[2]

While the GPRO is not an individual participation option, unless otherwise noted, participation information from eligible professionals who were part of group practices participating under the GPRO or as part of an ACO under the Medicare Shared Savings Program and the Pioneer ACO Model was combined with individual participants to describe the total number of eligible professionals that participated in the programs.

Summaries of Physician Quality Reporting System incentive payments exclude additional incentive payments for eligible professionals that meet specified requirements related to participation in Maintenance of Certification Programs (MOCPs), although some tables present

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

[2] Under the Medicare Shared Savings Program, CMS has incorporated certain Physician Quality Reporting System reporting requirements and incentives. Eligible professionals within ACOs that meet specific requirements are eligible to receive Physician Quality Reporting System bonuses and avoid the Physician Quality Reporting System payment adjustment under the Medicare Shared Savings Program or the Pioneer ACO Model.

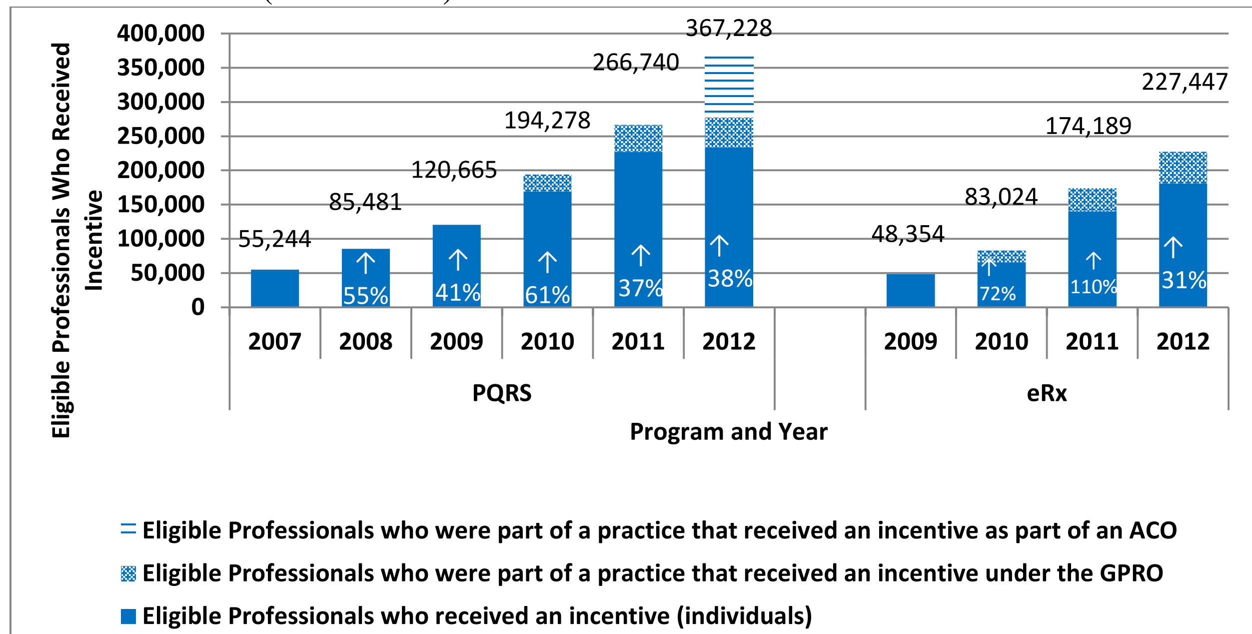
the additional incentive results separately.[3] For the eRx Incentive Program, counts of individually-participating incentive-eligible professionals and incentive dollar amounts for both individual eligible professionals and group practices shown in this report include those receiving an incentive through the Medicare EHR Incentive Program; see the eRx Incentive Program section of this report for more details (Section IV).

[3] Refer to section III.B of this report for more information on incentive payments related to participation in Maintenance of Certification Programs.

Incentive Payments

- Incentive eligible professionals earned a combined $503,146,409 through the Physician Quality Reporting System and the eRx Incentive Program in the 2012 program year.[4]

Figure 1: Number of Eligible Professionals Who Qualified for an Incentive: Physician Quality Reporting System Results (2007 to 2012) and eRx Incentive Program Results (2009 to 2012)



Note for Figure 1: Results included all participation mechanisms and options (i.e., claims, registry, EHR, and GPRO web interface [used by group practices reporting under the GPRO or ACOs reporting under the Medicare Shared Savings Program or Pioneer ACO Model]).

- The number of eligible professionals who qualify for an incentive payment under the Physician Quality Reporting System has increased each year since its inception (Figure 1).
- A total of $167,815,193 in Physician Quality Reporting System incentive payments were paid by CMS for the 2012 program year, which reflects successful participation of 29,254 practices that included 367,228 eligible professionals (Table 5).[5]
  - Total incentive payments for the 2012 Physician Quality Reporting System decreased by 35 percent compared to 2011 ($258,153,383).
  - The number of eligible professionals who qualified for an incentive for the 2012 Physician Quality Reporting System (367,228) increased 38 percent from 2011

[4] This total includes incentives earned by eligible professionals who were paid through the Medicare EHR Incentive Program rather than the eRx Incentive Program. See Section IV for more details.

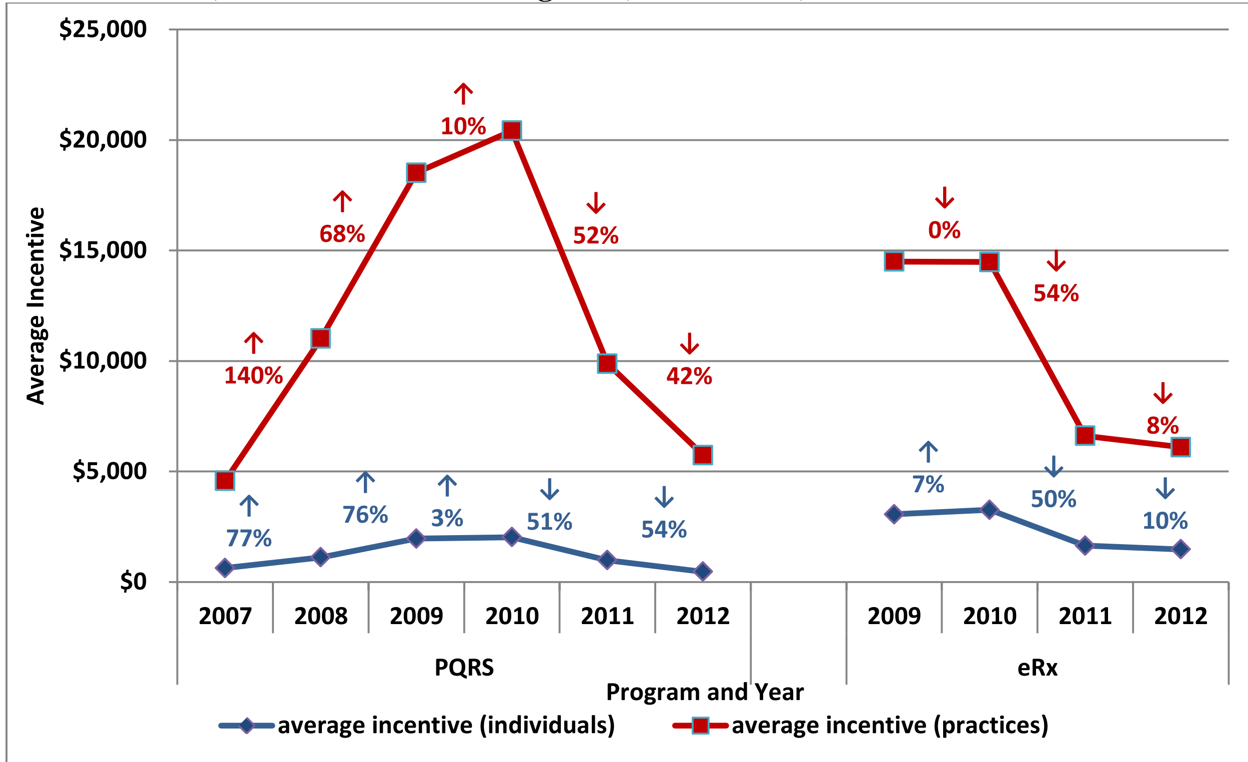
[5] These numbers include eligible professionals who participated individually, summarized at the practice level, as well as eligible professionals who were part of a group practice that participated under the GPRO or an ACO under the Medicare Shared Savings Program or Pioneer ACO Model.

(266,740) including eligible professionals who were part of a group practice that was incentive eligible under the GPRO or within an ACO.

- o Among all eligible professionals who could have participated in the Physician Quality Reporting System, 31 percent earned an incentive for the program in 2012, compared to 24 percent in 2011.
- o All 44,056 eligible professionals that participated under the GPRO were incentive eligible.
- o Nearly all 89,423 eligible professionals that participated as part of an ACO were incentive eligible (99.4 percent).
- o The number of practices that received an incentive for the 2012 program year (29,254) increased 10 percent compared to 2011 (26,575).
- o The average incentive was $457 per individually-participating eligible professional and $5,736 per practice; the average incentive decreased by about one-half from 2011 following a reduction in the incentive payment percentage from one percent to 0.5 percent (Figure 2).

- The number of eligible professionals who qualify for an incentive payment under the eRx Incentive Program has increased each year since its inception (Figure 1).
  - o A total of $335,331,216 in eRx Incentive Program incentives was paid for the 2012 program year, which included 227,447 eligible professionals meeting incentive eligibility criteria (including those who were part of an incentive eligible group practice that participated under the GPRO) and 55,015 practices (Table 5).
  - o Among all eligible professionals who could have participated in the eRx Incentive Program, 29 percent earned an incentive in 2012, compared to 23 percent in 2011.
  - o Total incentive payments for the 2012 eRx Incentive Program increased 18 percent compared to 2011 ($285,049,103).
  - o There were 63 practices that were incentive eligible and reported under the GPRO, they included 46,288 eligible professionals and were paid a total of $22,034,493.
  - o The number of practices that qualified for an incentive in the 2012 eRx Incentive Program (55,015) increased 28 percent compared to 2011 (43,132).
  - o The average eRx incentive payment was $1,474 per eligible professional and $6,095 per practice (Figure 2).

Figure 2: Average Incentive Payments for the Physician Quality Reporting System (2007 to 2012) and eRx Incentive Program (2009 to 2012)



Note for Figure 2: Results include incentives for participants under all participation mechanisms and options (i.e., claims, registry, EHR, and GPRO web interface [used by group practices reporting under the GPRO or eligible professionals within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model]).

Expansion of Programs and Eligibility

- The 2012 Physician Quality Reporting System and eRx Incentive Program generally retained the same reporting options (individual reporting options and group practice reporting options) as well as mechanisms (claims, registry, EHR, and web interface) from the 2011 program—although under the Medicare Shared Savings Program and Pioneer ACO Model, eligible professionals that were part of an ACO were able to earn a Physician Quality Reporting System incentive by participating via the ACO GPRO web interface in 2012 (Table 1).
- Sixty-eight practices self-nominated and were approved by CMS to participate in the Physician Quality Reporting System in 2012 under the GPRO, nine under the Small GPRO (25 to 99 eligible professionals) and 59 under the Large GPRO (100 or more eligible professionals).
    - Another 146 practices were approved by CMS to participate as Medicare ACOs for purposes of earning a Physician Quality Reporting System incentive under the Medicare Shared Savings Program or Pioneer ACO Model.

Table 1: Summary of Reporting Options and Mechanisms for the Physician Quality Reporting System, Medicare Shared Savings Program, Pioneer ACO Model, and eRx Incentive Program (2011 to 2013)

Reporting Options and Mechanisms	PQRS 2011	PQRS 2012	PQRS 2013	eRx 2011	eRx 2012	eRx 2013
Individual Eligible Professionals	--	--	--	--	--	--
Claims-based: Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes
Claims-based: Measures Groups	Yes	Yes	Yes	N/A	N/A	N/A
Registry: Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes
Registry: Measures Groups	Yes	Yes	Yes	N/A	N/A	N/A
Electronic Health Record (EHR): Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes
Group Practice Reporting	--	--	--	--	--	--
GPRO I web interface	Yes	N/A	N/A	N/A	N/A	N/A
GPRO I claims	N/A	N/A	N/A	Yes	N/A	N/A
GPRO I registry	N/A	N/A	N/A	Yes	N/A	N/A
GPRO I EHR	N/A	N/A	N/A	Yes	N/A	N/A
GPRO II claims	Yes	N/A	N/A	Yes	N/A	N/A
GPRO II registry	Yes	N/A	N/A	Yes	N/A	N/A
GPRO II EHR	N/A	N/A	N/A	Yes	N/A	N/A
Small GPRO web interface	N/A	Yes	N/A	N/A	N/A	N/A
Small GPRO claims	N/A	N/A	N/A	N/A	Yes	Yes
Small GPRO registry	N/A	N/A	Yes	N/A	Yes	Yes
Small GPRO EHR	N/A	N/A	N/A	N/A	Yes	Yes
Medium GPRO web interface	N/A	N/A	Yes	N/A	N/A	N/A
Medium GPRO claims	N/A	N/A	N/A	N/A	N/A	Yes
Medium GPRO registry	N/A	N/A	Yes	N/A	N/A	Yes
Medium GPRO EHR	N/A	N/A	N/A	N/A	N/A	Yes
Large GPRO web interface	N/A	Yes	Yes	N/A	N/A	N/A
Large GPRO claims	N/A	N/A	N/A	N/A	Yes	Yes
Large GPRO registry	N/A	N/A	Yes	N/A	Yes	Yes
Large GPRO EHR	N/A	N/A	N/A	N/A	Yes	Yes
Accountable Care Organizations (ACO) web interface – Medicare Shared Savings Program and Pioneer ACO Model	N/A	Yes	Yes	N/A	N/A	N/A

Notes for Table 1: In 2010, the Physician Quality Reporting System included a single option for group practices with 200 or more professionals (referred to as "GPRO I"). In 2011, the GPRO II option was added for practices with 2 to 199 professionals. In 2012, GPRO I and GPRO II were replaced with group practices reporting options for Large (100+ NPIs) and Small (25-99 NPIs) group practices. In 2013, reporting options for Small (2-24 NPIs), Medium (25-99 NPIs), and Large (100+ NPIs) group practices were available.

- In the eRx Incentive Program, eight practices self-nominated under the Small GPRO and 61 practices self-nominated under the Large GPRO.
- The number of quality measures from which eligible professionals could choose to participate in the Physician Quality Reporting System continued to increase in the 2012 program, particularly for reporting measures groups and reporting via registry and EHR reporting mechanisms (Table 2).

Table 2: Number of Physician Quality Reporting System Measures (2010 to 2013)

Mechanism or Option	2010	2011	2012	2013
Total Number of Measures	179	198	266	258
Number of Measures Groups	13	14	22	22
Number of measures within measures groups	76	78	117	119
Number of measures reportable via claims	129	131	143	137
Number of measures reportable via registry	175	186	208	203
Number of measures reportable via EHR	10	20	51	51
Number of measures reportable via GPRO[a]	26	26	29	22
Number of measures reportable via ACO	N/A	N/A	22	22

Notes for Table 2: Total number of measures reflects all measures, including all possible reporting mechanisms and options. Refer to Section III.A. for more information about how the group reporting option has changed over time. [a] GPRO counts reflect the web interface measures only.

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

Table 3: Top Five Individual Measures Reportable by the Largest Number of Eligible Professionals for the Physician Quality Reporting System (2012)

Measure Number	Measure Name	Eligible Professionals
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	748,413
131	Pain Assessment and Follow-Up	705,787
130	Documentation of Current Medications in the Medical Record	705,256
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	682,207
317	Preventive Care and Screening: Screening for High Blood Pressure	663,267

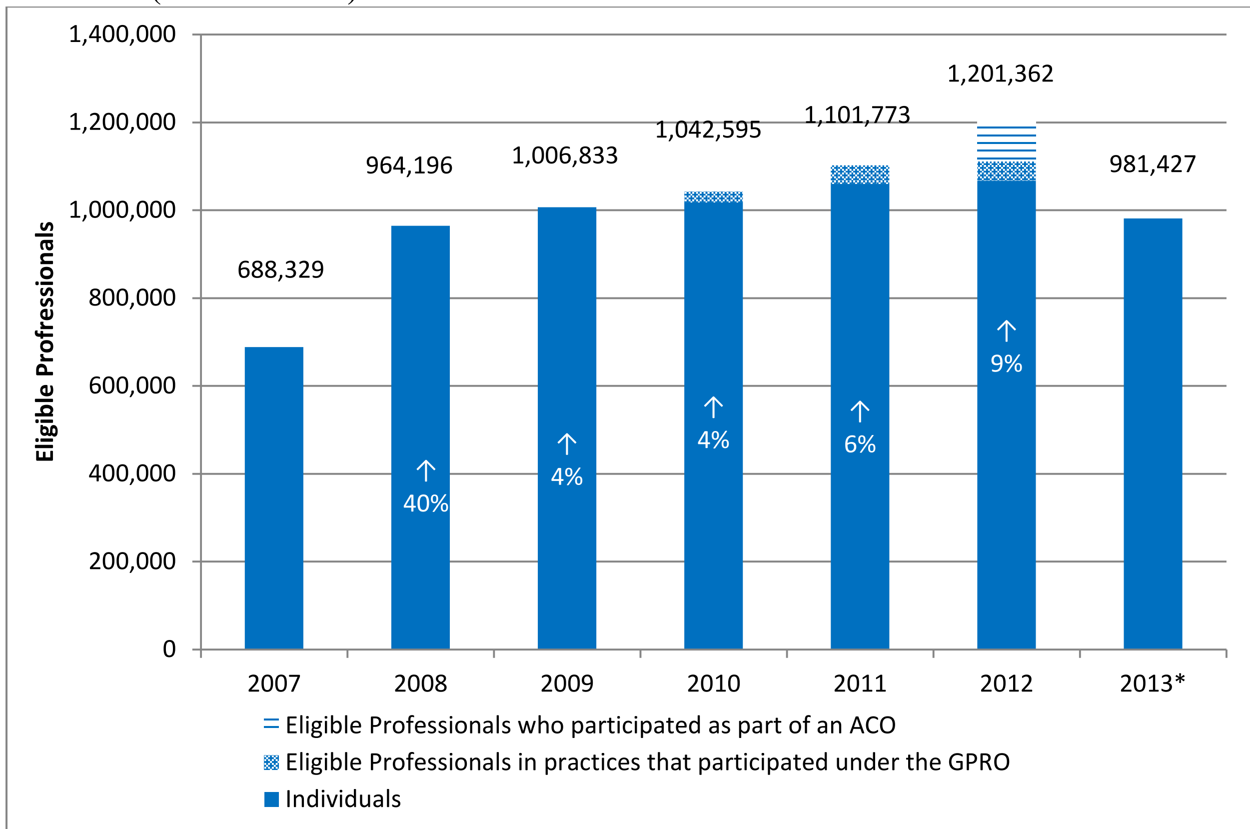
Note for Table 3: Results include the claims, registry, and EHR mechanisms, excluding eligible professionals who were part of a practice that participated under the GPRO or as part of an ACO under the Medicare Shared Savings Program or Pioneer ACO Model.

- More than 1.2 million eligible professionals were eligible to participate in the 2012 Physician Quality Reporting System (Figure 3), Medicare Shared Savings Program, and Pioneer ACO Model.
- Specialties with large numbers of eligible professionals who were eligible to participate in the Physician Quality Reporting System included internal medicine, family practice,

nurse practitioners, physician assistants, and emergency medicine. CMS aims to include quality measures that are applicable to all specialties and annually requests suggestions for measures to be included in the Physician Quality Reporting System (Appendix Table A6).

- 778,904 eligible professionals could have participated in the 2012 eRx Incentive Program including those who were part of a group practice that self-nominated and indicated their intent to report eRx were able to participate via the GPRO for the eRx Incentive Program.

Figure 3: Total Number of Professionals Eligible to Participate in the Physician Quality Reporting System, Medicare Shared Savings Program, and Pioneer ACO Model (2007 to 2013*)



*Notes for Figure 3: Results include all reporting mechanisms and options. *2013 is preliminary data (six months) and does not include reporting via Registry, EHR, or the GPRO web interface (used by group practices reporting under the GPRO or eligible professionals within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model).*

Participation[6]

- Participation increased every year in both the Physician Quality Reporting System and eRx Incentive Program (Figures 4 and 5).
    - The number of eligible professionals who participated increased by 36 percent and 22 percent for the Physician Quality Reporting System and eRx Incentive Program, respectively from 2011 to 2012.
- In 2012, 435,871 (36 percent) eligible professionals (including those who belonged to group practices that reported under the GPRO and eligible professionals within an ACO) participated in the Physician Quality Reporting System, Medicare Shared Savings Program, or Pioneer ACO Model through at least one method, a four-fold increase from the roughly 100,000 who participated in 2007.[7]
    - In 2012, 89,941 eligible professionals participated under the GPRO as part of an ACO, while another 44,056 eligible professionals participated under the Physician Quality Reporting System GPRO.
- The participation rate among all eligible professionals using any method to participate in the Physician Quality Reporting System increased from 15 percent to 36 percent between 2007 and 2012, including those who belong to group practices that participated under the GPRO or as part of an ACO under the Medicare Shared Savings Program or Pioneer ACO Model.
    - While the most common participation method in the Physician Quality Reporting System continues to be reporting individual measures through claims, participation across most reporting mechanisms increased each year from 2008 to 2012. There was a drop in registry-based measures group participants from 2010 to 2012 as well as a drop in the number reporting individual registry measures from 2011 to 2012 (Figure 4). EHR reporting had marked increases each year from 2010 to 2012.
- In 2012, 19,817 eligible professionals submitted quality data for the Physician Quality Reporting System through a qualified EHR, while 7,858 eligible professionals submitted quality data through the eRx Incentive Program EHR mechanism. This is a substantial increase from 2011 when 560 eligible professionals submitted data through a qualified EHR under the Physician Quality Reporting System and 104 eligible professionals did so under the eRx Incentive Program.
- Of the 68 practices that self-nominated to participate under the Physician Quality Reporting System GPRO, 66 practices participated, encompassing 766 eligible professionals under eight practices using the Small GPRO and 43,290 eligible professionals under the 58 practices using the Large GPRO.

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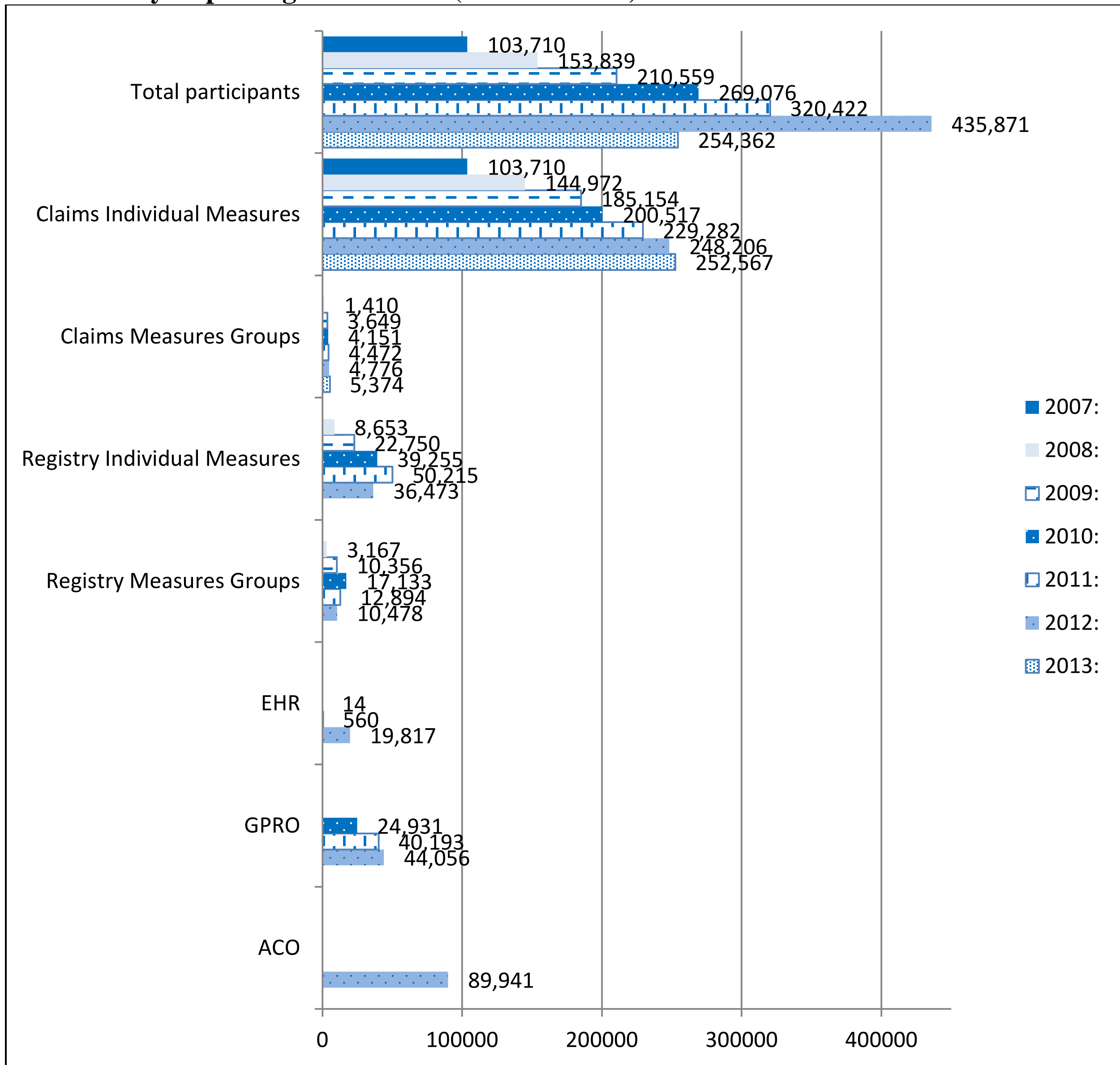
[6] For the Physician Quality Reporting System, participation results include the eligible professionals who are part of an ACO reporting through the web interface under the Medicare Shared Savings Program or Pioneer ACO Model.

[7] Refer to Section III for a description of measure submission approaches.

- In addition, seven group practices (encompassing 650 eligible professionals) participated in the eRx Incentive Program under the Small GPRO and 59 practices (encompassing 46,088 eligible professionals) participated under the Large GPRO.
- There were 144 ACOs that, for the purpose of earning a Physician Quality Reporting System incentive, reported under the Medicare Shared Savings Program (112 ACOs) or Pioneer ACO Model (32 practices).

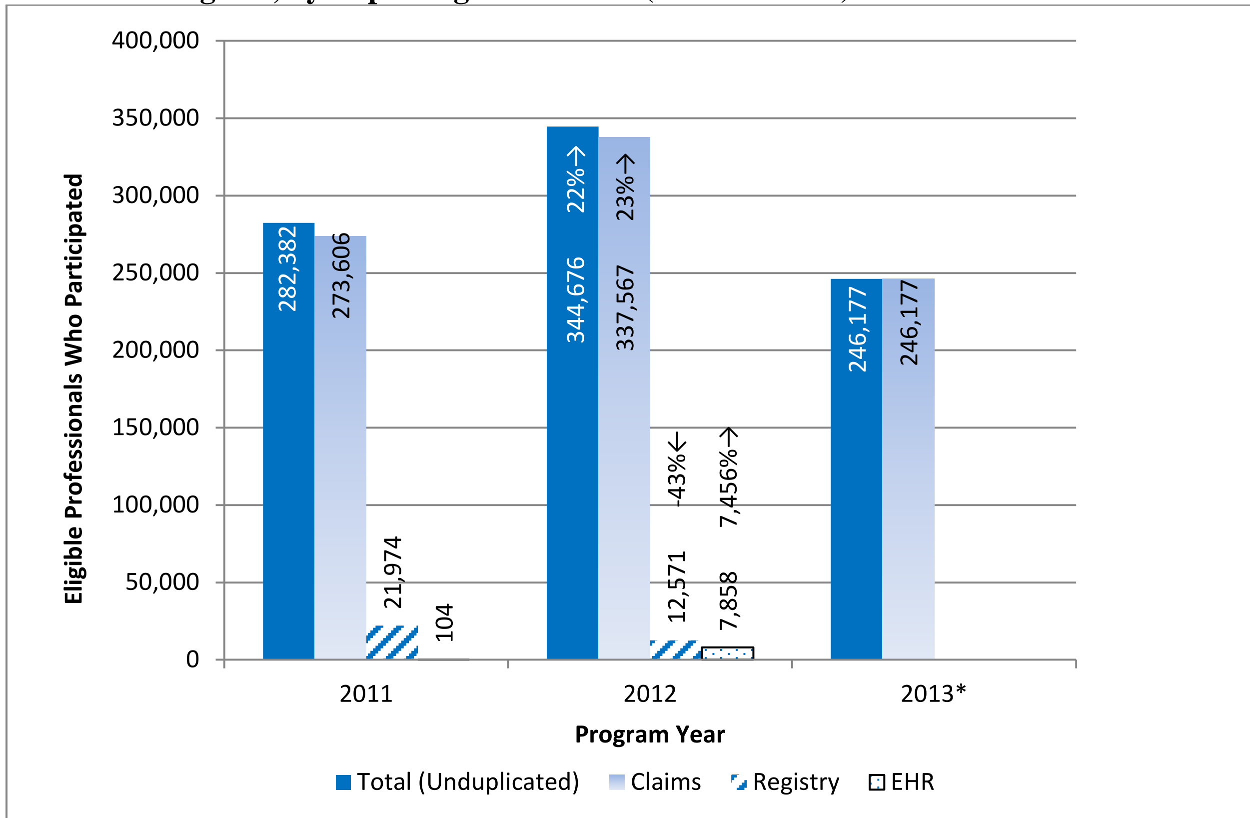
Figure 4: Total Number of Eligible Professionals Participating in the Physician Quality Reporting System, Medicare Shared Savings Program, and Pioneer ACO Model by Reporting Mechanism (2007 to 2013*)



Note for Figure 4: Results include individually participating eligible professionals as well as eligible professionals in group practices that participated under the GPRO. Although the table generally describes the Physician Quality Reporting System, it also includes information about eligible professionals participating in the Medicare Shared Savings Program and the Pioneer ACO Model. Some eligible

*professionals participated in more than one method. *Results for 2013 are preliminary only (six months); data reported via registry, EHR, and under the GPRO web interface (used by group practices reporting under the GPRO and ACOs reporting under the Medicare Shared Savings Program or Pioneer ACO Model) are not yet available.*

Figure 5: Total Number of Eligible Professionals Participating in the eRx Incentive Program, by Reporting Mechanism (2011 to 2013*)



*Notes for Figure 5: Results include individually participating eligible professionals as well as eligible professionals in group practices that participated under the GPRO. *Results for 2013 are preliminary only (six months); data reported via registry, EHR, and all data for group practices participating under the GPRO are not yet available.*

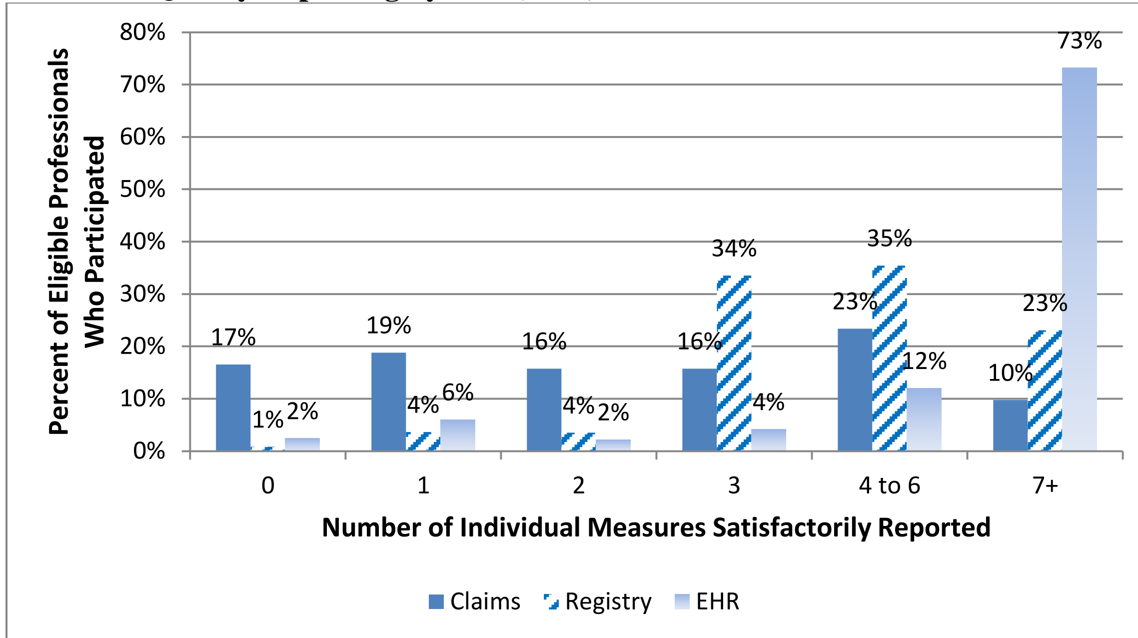
- In 2012, 344,676 eligible professionals participated in the eRx Incentive Program with 98 percent participating through claims (Figure 5).
- In 2012, 44 percent of those eligible to participate participated in the eRx Incentive Program, an increase from 38 percent of those eligible in 2011 (includes those participating under the GPRO); the number of individual participants in the eRx Incentive Program increased by 22 percent from 2011 to 2012.
    - Preliminary data for 2013 eRx Incentive Program show the number of individual eligible professionals who participated (excluding GPRO participants) by reporting through claims during the first six months of 2013 is approximately 70 percent of all eRx Incentive Program participants using any reporting mechanism during 2012.

- For the eRx Incentive Program, some specialties participated in greater numbers and/or at higher rates in the 2012 programs than others.
    - Internists, family practitioners, and emergency medicine physicians had the largest numbers of participants in the Physician Quality Reporting System across all reporting options. Pathologists and emergency medicine physicians had the highest participation rates of any specialty (69 percent and 68 percent, respectively).
    - Among all specialties with at least 1,000 eligible professionals participating, family practitioners, internists and nurse practitioners had the largest number of participants in the eRx Incentive Program. Nurse anesthetists, rheumatologists, and cardiologists had the highest participation rates (92 percent, 74 percent, and 73 percent, respectively).
- A large percentage of eligible professionals and practices participated in both the Physician Quality Reporting System and the eRx Incentive Program (Table 4).
    - In 2012, 199,785 individual eligible professionals (48 percent of those who were eligible to participate in both programs) and 26,649 practices (33 percent of those eligible to participate in both programs) participated in both programs.

Satisfactory Reporting and Challenges to Reporting

- In 2012, 83 percent of eligible professionals who participated in the Physician Quality Reporting System satisfactorily reported at least one individual measure through claims, compared with 99 percent of registry participants and 98 percent of EHR participants (Figure 6).
    - That is, 17 percent of those who attempted to participate via claims were unable to submit any measures satisfactorily, compared to one percent for those using a registry or two percent using an EHR.
- The most common claims-based submission error was reporting a measure-specific Quality Data Code (QDC) on a claim that did not also have the required procedure code.
- The most common reporting errors via registry were incorrect performance rates and submitting data for an eligible professional that had no Part B MPFS allowed charges.
- The most common errors for EHR reporting were: invalid HIC numbers; the inclusion of eligible professionals who participated via the GPRO or ACO; and eligible professionals without MPFS charges.

Figure 6: Distribution of Satisfactorily Reporting Individual Measures for the Physician Quality Reporting System (2012)



Note for Figure 6: Satisfactory reporting required reporting at least 50 percent of eligible instances for claims-based reporting and 80 percent of eligible instances for registry- and EHR-based reporting. The results for '0' above indicate that no measures were reported satisfactorily.

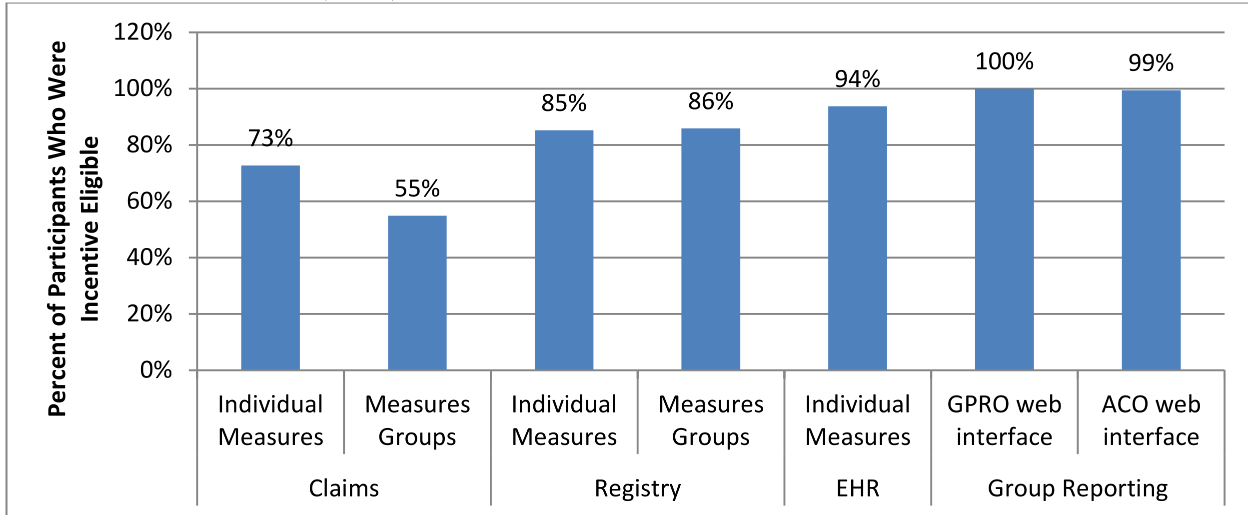
Incentive Eligibility[8]

- Across all reporting options, more than eight in ten participants (84 percent) in the 2012 Physician Quality Reporting System met the criteria for incentive eligibility.[9]
- About three-quarters (73 percent) of eligible professionals who participated by reporting individual measures through the claims mechanism in the 2012 Physician Quality Reporting System earned an incentive (Figure 7).
  - Incentive eligibility rates for the Physician Quality Reporting System were highest (85 percent or higher) for the following reporting mechanisms: registry (both individual measures and measures groups), EHR, GPRO web interface, and ACO GPRO web interface.

[8] For the Physician Quality Reporting System, incentive eligibility results include eligible professionals who earned an incentive as part of an ACO under the Medicare Shared Savings Program or Pioneer ACO Model.

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

Figure 7: Incentive Eligibility Rate by the Physician Quality Reporting System Reporting Mechanism (2012)



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

- Two-thirds of eligible professionals (66 percent) who participated in the 2012 eRx Incentive Program qualified for an incentive (including eligible professionals who were part of a group practice that reported under the GPRO). The incentive eligibility rate increased modestly from 62 percent in 2011.
- Two-thirds of eligible professionals (66 percent) who participated in both the Physician Quality Reporting System (including ACOs under the Medicare Shared Savings Program and Pioneer ACO Model) and the eRx Incentive Program qualified for an incentive through both programs (Table 4).
    - There were 199,785 eligible professionals who participated in both the Physician Quality Reporting System and the eRx Incentive Program in 2012, and among these, 132,069 were incentive eligible for both programs.

Table 4: Eligible Professionals and Practices Participating in Both the Physician Quality Reporting System and eRx Incentive Program (2011 to 2013*)

Interaction of Participation and Incentives for eRx and PQRS	Eligible Professionals in 2011	Eligible Professionals in 2012	Eligible Professionals in 2013	Practices in 2011	Practices in 2012	Practices in 2013
Participated in Either Program	465,361	580,762	418,166	80,977	94,519	92,227
Participated in PQRS or eRx and Eligible for Both Programs	327,111	416,864	275,183	74,279	81,600	77,104
Participated in Both Programs	137,443	199,785	81,935	22,269	26,649	21,810
Percent Participated who were Eligible for Both Programs	42.0%	47.9%	29.8%	30.0%	32.7%	28.3%
Incentive Eligible for Both Programs	87,325	132,069	--	13,208	15,534	--
Percent Incentive Eligible who Participated in Both Programs	63.5%	66.1%	--	59.3%	58.3%	--
Total Payments to those in Both Programs	$265,845,376	$265,864,267	--	$336,729,504	$274,756,421	--
Average Payments to those in Both Programs	$3,044	$2,013	--	$25,494	$17,687	--

Notes for Table 4: (1) Results for 2013 are preliminary only; incentive information was not yet available. (2) Data include eligible professionals who were part of a practice that participated under the GPRO as well as eligible professionals within an ACO that reported under the Medicare Shared Savings Program or Pioneer ACO Model.

- Between both programs, incentives earned totaled $503,146,409 in 2012, the majority through the eRx Incentive Program (Table 5).

Table 5: Eligible Professionals' and Practices' Reporting Results for the Physician Quality Reporting System and eRx Incentive Program (2012)

Outcome and Mechanism	Eligible Professionals in PQRS	Eligible Practices in PQRS	Eligible Professionals in eRx	Eligible Practices in eRx
Eligible	1,201,362	292,335	778,904	225,109
Participated via Any Method	435,871	42,522	344,676	78,646
Participated via Claims	249,492	35,168	292,367	78,299
Participated via Registry	46,642	7,548	11,033	1,051
Participated via EHR	19,817	2,179	7,858	523
Participated via Small GPRO	766	8	650	7
Participated via Large GPRO	43,290	58	46,088	59
Participated via ACO	89,941	144	n/a	n/a
Incentive Eligible	367,228	29,254	227,447	55,015
Total Incentive Payments	$167,815,193	$167,815,193	$335,331,216	$335,331,216
Average Incentive Payments	$457	$5,736	$1,474	$6,095

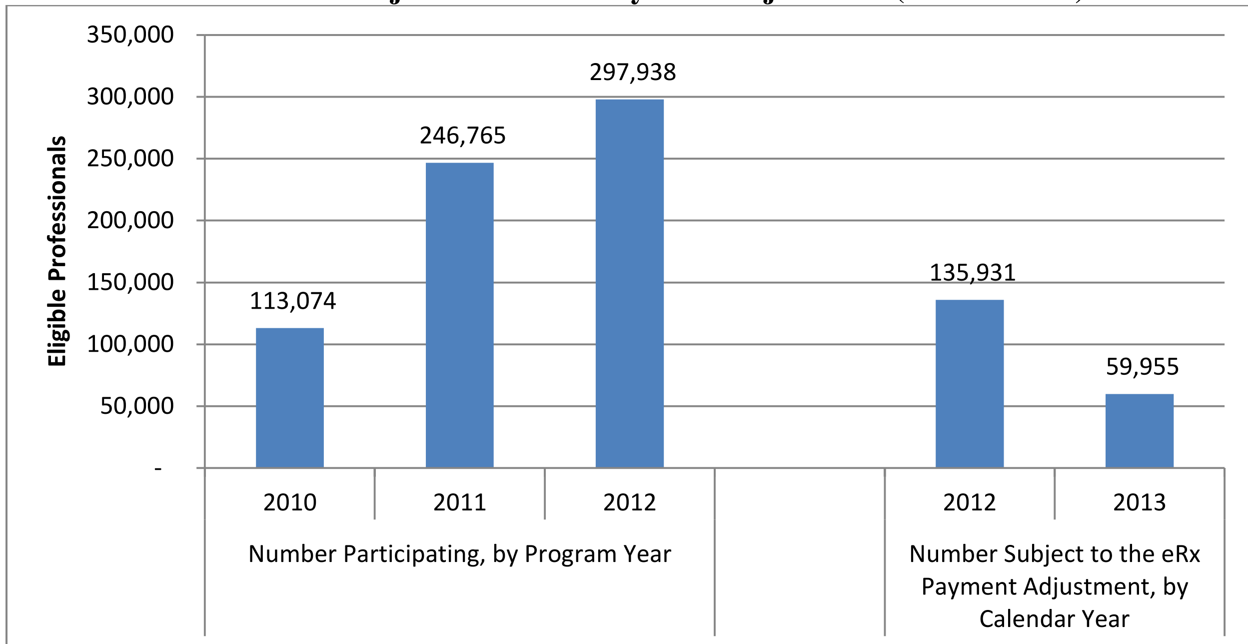
Note for Table 5: Some eligible professionals participated in more than one reporting method. Results include eligible professionals who were part of a practice that participated under the GPRO. Although the table generally describes the Physician Quality Reporting System, it also includes information about eligible professionals participating in Medicare ACOs for purposes of reporting Physician Quality Reporting System data through the Medicare Shared Savings Program and the Pioneer ACO Model.

2013 eRx Payment Adjustment

- 59,955 eligible professionals (including those participating under the GPRO) were subject to the 2013 eRx payment adjustment because they either did not qualify for an exemption, meet exclusion criteria for the adjustment, were not successful e-prescribers in 2011, or did not meet eRx reporting requirements in the first half of 2012.
  - Over 75 percent of those subject to the payment adjustment did not participate in the eRx Incentive Program at all.
- Among the eligible professionals who avoided the 2013 payment adjustment:
  - 231,449 did not have enough eligible cases; 124,993 were not in a qualifying specialty (MD/DO, podiatrist, nurse practitioner, or physician assistant); and 5,756 did not meet the 10 percent limitation threshold.
  - 152,705 eligible professionals reported the required number of eRx cases and 13,325 were successful electronic prescribers in 2011.
  - Excluding the eligible professionals who were granted a hardship exemption for one of the reasons in the two previous bullets, there were 37,553 who had an exemption related to Meaningful Use and another 16,087 eligible professionals who were granted an exemption either via the Communication Support Page (CSP) or through CMS informal review.

- As seen in Figure 8, the number of electronic prescribers has been increasing steadily and, accordingly, the number of eligible professionals subject to a payment adjustment has been declining.

Figure 8. Electronic Prescribing Trends – Participation (2010 to 2012) and Eligible Professionals Subject to the eRx Payment Adjustment (2012 to 2013)



Summary

In summary, the growth of the Physician Quality Reporting System and eRx Incentive Program in 2012 supported continued progress toward the CMS goals of promoting quality measure reporting for Medicare beneficiaries and alignment across quality measure reporting programs. The number of eligible professionals who participated and earned an incentive in the Physician Quality Reporting System and the eRx Incentive Program continued to grow in the 2012 program year. Most eligible professionals who participated in either program were successful reporters and qualified for an incentive payment. Among all eligible professionals who could have participated in either program (including those in group practices that participated under the GPRO or as part of an ACO), 31 percent earned an incentive for the Physician Quality Reporting System and 29 percent earned an incentive for the eRx Incentive Program (data not shown).

The Physician Quality Reporting System collected quality information on nearly 15 million Medicare beneficiaries through claims in 2012. An additional 13 million beneficiaries had electronic prescriptions submitted by more than 344,000 eligible professionals in 78,000 practices who adopted and used certified electronic prescribing systems. CMS further encouraged the use of certified EHR systems by expanding the set of EHR-based quality measures in 2012.

II. INTRODUCTION[10]

The Centers for Medicare & Medicaid Services (CMS) implemented two pay-for-reporting programs for eligible professionals. The Physician Quality Reporting System, authorized under Section 101(b) of division B of the TRHCA of 2006 (Public Law 109-423; 120 Stat. 2975) entered its sixth year in 2012 and has grown substantially from its inception in 2007. The Electronic Prescribing (eRx) Incentive Program, authorized under section 132 of the MIPPA, began in 2009. Currently, these programs reward eligible professionals with bonus incentives — determined based on a percentage of the estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional during the applicable reporting period – and provide for payment adjustments based on whether eligible professionals meet applicable requirements for reporting information on standardized clinical quality measures.

This report summarizes the results of eligible professionals who participated in these programs in 2012 and provides historical trends and preliminary 2013 results. Section III of this report presents detailed findings for the Physician Quality Reporting System and Section IV presents similar information for the eRx Incentive Program. Sections V and VI describe information about feedback reports available under the Physician Quality Reporting System and the eRx Incentive Program and the services available from the Help Desk. Section VII provides overall conclusions. The Appendix is a separate document for interested readers, which contains additional descriptions of data and methods, as well as detailed tables of results.

This report uses the term "eligible professional" to describe physicians and other health care professionals who could participate in the Physician Quality Reporting System and eRx Incentive Program. The health professionals who are eligible to participate in the Physician Quality Reporting System and eRx Incentive Program are precisely defined on the CMS website.[11] In general, this includes professionals who furnish MPFS covered services to Medicare Part B (including Railroad Retirement Board RRB and Medicare Secondary Payer MSP) beneficiaries for whom selected Physician Quality Reporting System measure(s) or the eRx Incentive Program measure are applicable.

The unit of analysis for describing eligible professionals was a combination of a professional's National Provider identifier (NPI) number and the Taxpayer Identification Number (TIN) under which they billed for services; this is commonly referred to as a "TIN/NPI" (please see the Appendix for more detail). Findings reported at the practice level include both eligible professionals participating individually, summarized at the practice level, as well as practices

[10] The information and data in these sections generally address the Physician Quality Reporting System and eRx Incentive Programs, but also include certain data related to eligible professionals within ACOs under the Medicare Shared Savings Program and Pioneer ACO Model given that eligible professionals within ACOs may report through those programs/models for the purposes of earning a Physician Quality Reporting System incentive. However, such eligible professionals participating in such initiatives outside the traditional Physician Quality Reporting System are subject to the reporting, participation, and program requirements specific to the Medicare Shared Savings Program and Pioneer ACO Model. Unless otherwise indicated, the program requirements discussed below (e.g. reporting options, mechanisms, periods, criteria, measures, participation rules, etc.) generally pertain to the Physician Quality Reporting System.

[11] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS and http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive

that participated through the group practice reporting option (GPRO); for the Physician Quality Reporting System incentive only, the group results also include eligible professionals within an Accountable Care Organization (ACO) under the Medicare Shared Savings Program or Pioneer ACO Model. While the GPRO is not an individual participation option, unless otherwise noted, the participation information from the GPRO was combined with individual participation options to describe the total number of individual eligible professionals that participated in the programs.

III. PHYSICIAN QUALITY REPORTING SYSTEM

A. Background

Program Description

The Physician Quality Reporting System is part of an overall effort to move toward a value-based purchasing (VBP) system that aims to reward the value of care provided, rather than the quantity of services. To this end, the Physician Quality Reporting System quality measures are intended to define, standardize and drive improvement in the quality of health care. An incentive (or payment adjustment), applicable to professionals who satisfy (or don't satisfy) the criteria for reporting quality data under the Physician Quality Reporting System, are intended to encourage professionals to adopt evidence-based, outcomes-driven healthcare delivery practices.

The authorizing legislation for the program is contained in Section 101(b) of Division B (Medicare Improvements and Extension Act of 2006 [MIEA]) of the TRHCA, which was enacted on December 20, 2006. Section 101(b) of the MIEA-TRHCA added subsection K to section 1848 of the Social Security Act and required the establishment of a quality reporting system. CMS initially referred to the Physician Quality Reporting System as the Physician Quality Reporting Initiative or PQRI.

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

Program Evolution

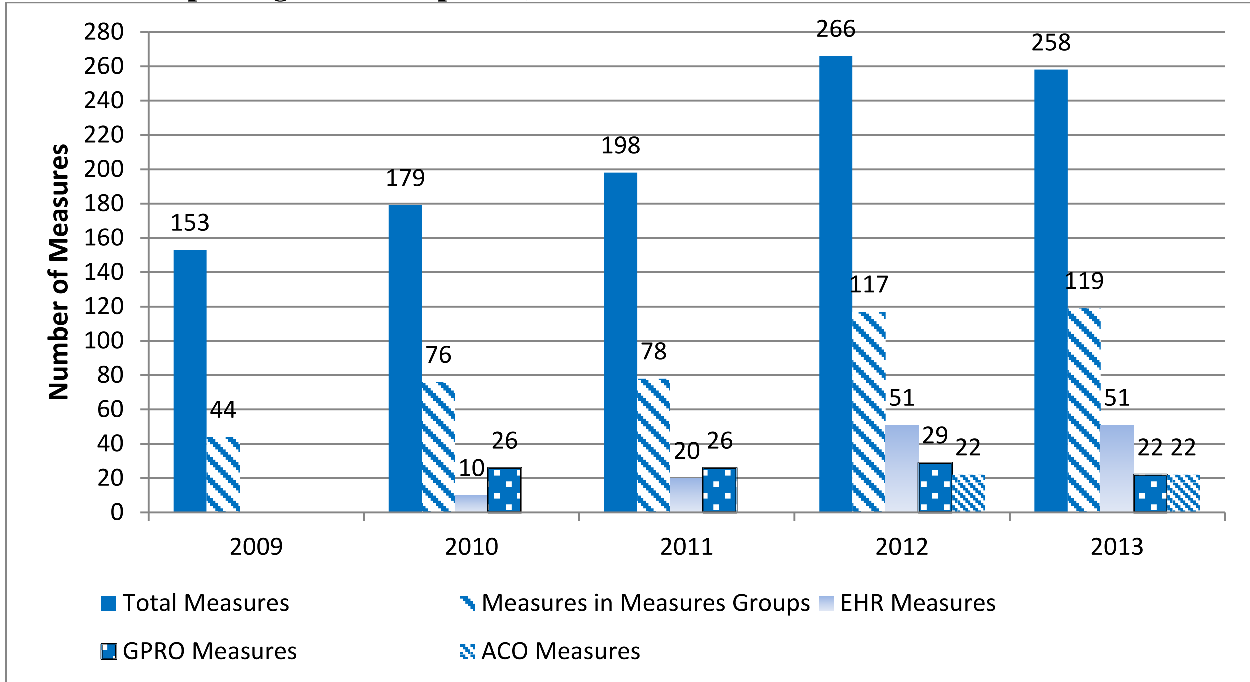
Measures for the 2007 program were defined by the TRHCA as quality measures that were developed under the Physician Voluntary Reporting Program (PVRP) and published on the CMS website as of the date of enactment of the TRHCA. The statute also provided that measures could be changed by the Secretary through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

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

MMSEA authorized incentive payments for 2008 and removed the cap on the total earned incentive amount previously mandated by TRHCA. Additionally, the MMSEA required that CMS establish alternative reporting periods, criteria for reporting groups of clinically-related measures, and collecting quality information through a clinical data registry. Registries do not require QDCs to accept clinical data. In 2008, MIPPA (Pub. Law 110-275, section 131(b)) made changes to the quality measure requirements as well as authorized incentives through 2010. In 2009 and 2010, the applicable quality percent for the incentive was set at two percent; it was decreased to one percent in the 2011 program and to one-half percent for the 2012 program. The Affordable Care Act made a number of changes to the Physician Quality Reporting System, including authorizing incentive payments through 2014 and requiring a penalty, beginning in 2015, for eligible professionals who do not satisfactorily report. The Patient Protection and Affordable Care Act, Pub. Law 11-148, enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. Law 111-115, and collectively known as the Affordable Care Act, also authorized an additional incentive (the applicable quality percent under the Physician Quality Reporting System is increased by one-half percent) for 2011 through 2014 for eligible professionals who satisfactorily report data on quality measures under the Physician Quality Reporting System and satisfy certain requirements related to participation in a Maintenance of Certification Program (MOCP).

CMS has continued to expand the number of measures and reporting options for the Physician Quality Reporting System each year (Figure 9). For example, the total number of measures available was 153, 179, and 198 in 2009, 2010, and 2011, respectively. The 2012 program year expanded the measure set to 266 total measures. The 2013 program has 258 total measures; 10 measures were added and 18 measures were retired. Appendix Table A1 lists all individual measures that could be reported in the program during 2012.

Figure 9: Number of Individual Measures in the Physician Quality Reporting System by Reporting Method/Option (2009 to 2013)



Note for Figure 9: Categories are not mutually exclusive; for example, an individual measure can also be part of a measures group. GPRO counts for the Physician Quality Reporting System in 2011 do not include the GPRO II reporting option. The number of measures in Figure 9 also include measures reported by eligible professionals within ACOs through the Medicare Shared Services Program or the Pioneer ACO Model.

For the Physician Quality Reporting system, measures groups were introduced in the 2008 program year and expanded each year thereafter (Figure 9). Measures groups are a subset of four or more clinically-related measures. The 2008 program included four measures groups that could be reported via the claims or the registry mechanisms. The 2009 program added four measures groups and retired one, for a total of seven measures groups, one of which was reportable via the registry mechanism only. Beginning in 2009, CMS also introduced a new QDC that allowed eligible professionals reporting on measures groups to use a single code to indicate if all recommended quality actions were performed for each measure in the group. That is, eligible professionals could report a single QDC—referred to as a composite G-code—for the entire measures group. Before this code existed, eligible professionals reported one QDC for each measure within the measures group. The 2010 program added six measures groups, three of which were reportable via registry only, for a total of 13 measures groups.

Moreover, in an effort to simplify measures group reporting, the 2009 program year requirement to report on consecutive patients was removed. That is, beginning in the 2010 program year, eligible professionals could report a measures group measure on 30 non-consecutive beneficiaries—appropriate for the measures group—during the reporting period. This change applied to reporting measures groups through both claims and a registry. The 2011 program added one additional measures group for a total of 14, while the 2012 program added eight new measures groups (six registry only) for a total of 22:

- Asthma (four measures)
- Back pain (four measures) – measures group only
- [New] Cataracts (four measures) – registry only
- Chronic kidney disease (CKD) (four measures)
- [New] Chronic obstructive pulmonary disease (COPD) (five measures)
- [New] Cardiovascular prevention (CVP) (six measures)
- Community-acquired pneumonia (CAP) (four measures)
- Coronary artery bypass graft (CABG) surgery (10 measures) – registry only
- Coronary artery disease (CAD) (four measures) – registry only
- [New] Dementia (nine measures) – registry only
- Diabetes mellitus (six measures)
- Heart failure (four measures) – registry only
- Hepatitis C (eight measures)
- HIV/AIDS (eight measures) – registry only
- [New] Hypertension (eight measures) – registry only
- [New] Inflammatory bowel disease (IBD) (eight measures) – registry only
- Ischemic vascular disease (IVD) (four measures)
- [New] Parkinson’s disease (six measures) – registry only
- Perioperative care (four measures)
- Preventive care (nine measures)
- Rheumatoid arthritis (six measures)
- [New] Sleep apnea (four measures) – registry only

As seen in Figure 9, the number of measures reportable via the EHR option has expanded from ten measures in 2010 to 51 measures in 2012 and 2013. The measures under the GPRO grew modestly from 26 in 2010 and 2011 to 29 in 2012 and were reduced to 22 in 2013. In addition to

expanding the available measures, CMS has continued to refine the avenues for participation in the Physician Quality Reporting System, as shown in Tables 6 and 7. Reporting via a qualified EHR vendor directly was added to the program in 2010. In 2012, CMS added an EHR data submission vendor reporting mechanism, under which eligible professionals could work with an approved data submission vendor to submit EHR data, rather than directly submitting EHR data.

Group reporting was introduced in 2010 for practices with 200 or more eligible professionals. GPRO reporting differs from reporting for individually participating eligible professionals. To participate through the GPRO, a group practice self-nominates with CMS. Among practices that met requirements and were approved to participate through the GPRO, CMS provided a web interface containing a pre-selected sample of patients with select patient demographic and utilization characteristics.[12] The practices were responsible for completing data fields to report specific quality actions for GPRO measures for the selected patients. The GPRO was expanded in 2011 to include, in addition to GPRO I for practices with 200 more eligible professionals, GPRO II for practices with 2 to 199 eligible professionals. In 2012, GPRO I and GPRO II were replaced with Small GPRO for practices with 25 to 99 eligible professionals and Large GPRO for practices with 100 or more eligible professionals. In 2013, the GPRO option was further refined to include: Small GPRO (2 to 24 eligible professionals), Medium GPRO (25 to 99 eligible professionals, and Large GPRO (100 or more eligible professionals).

[12] In the 2011 program, only GPRO I used the web interface for reporting; GPRO II practices used claims, registry, or EHR reporting. In both 2010 and 2012, GPROs universally reported via one method, a database tool and an online web interface, respectively.

Table 6: Summary of Reporting Mechanisms in the Physician Quality Reporting System (2007 to 2013)

Reporting Mechanisms	2007	2008	2009	2010	2011	2012	2013
Claims Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Claims Measures Groups	No	Yes	Yes	Yes	Yes	Yes	Yes
Registry Individual Measures	No	Yes	Yes	Yes	Yes	Yes	Yes
Registry Measures Groups	No	Yes	Yes	Yes	Yes	Yes	Yes
Electronic Health Record (EHR) Individual Measures	No	No	No	Yes	Yes	Yes	Yes
Group Practice Reporting Option (GPRO) web interface	No	No	No	Yes	Yes	Yes	Yes
Accountable Care Organizations (ACO) web interface	No	No	No	No	No	Yes	Yes

Note for Table 6: For the Physician Quality Reporting System, GPRO was a reporting option for practices with 200 or more professionals in 2010. In 2011, the GPRO II option was added for practices with 2 to 199 professionals. In 2012, GPRO I and GPRO II were replaced with Large (100+ NPIs) and Small GPRO (25-99 NPIs). In 2013, the GPRO includes Small (2-24 NPIs), Medium (25-99 NPIs), and Large (100+ NPIs).

Table 7: Summary of Physician Quality Reporting System Incentives, Measures and Reporting Criteria for Eligible Professionals Participating as Individuals (2010 to 2013)[13]

Statistic	2010	2011	2012	2013
Applicable Quality Percent[a]	2% of Part B MPFS allowed charges	1% of Part B MPFS allowed charges	0.5% of Part B MPFS allowed charges	0.5% of Part B MPFS allowed charges[b]
Number of Measures and Measures Groups	179 Total Measures 13 Measures groups	198 Total Measures 14 Measures groups	266 Total Measures 22 Measures groups	258 Total Measures 22 Measures groups
Individual Measures Reporting Criteria	· Claims: 3 measures (or 1-2 measures subject to MAV) and 80% of eligible instances · Registry & EHR: have to report a minimum of 3 measures and 80% of eligible instances	· Claims: 3 measures (or 1-2 measures subject to MAV) and 50% of eligible instances · Registry & EHR: have to report a minimum of 3 measures and 80% of eligible instances	· Claims: 3 measures (or 1-2 measures subject to MAV) and 50% of eligible instances · Registry & EHR: have to report a minimum of 3 measures and 80% of eligible instances · EHR only: report all 3 EHR Incentive Program core measures or, if the denominator for one or more of these is zero, report up to three EHR Incentive Program alternate core measures AND report three additional measures available for the Medicare EHR incentive Program	· Claims: 3 measures (or 1-2 measures subject to MAV) and 50% of eligible instances · Registry & EHR: have to report a minimum of 3 measures and 80% of eligible instances · EHR only: report all 3 EHR Incentive Program core measures or, if the denominator for one or more of these is zero, report up to three EHR Incentive Program alternate core measures AND report three additional measures available for the Medicare EHR incentive Program

[13] For further details, see the Calendar Year 2012 Medicare Physician Fee Schedule (PFS) Final Rule at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS1253669.html

Statistic	2010	2011	2012	2013
Measures Group Reporting Criteria[c]	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)	Report on all measures in at least 1 MG for: · 50% eligible Medicare patients (min of 8 or 15 patients) via Claims · 80% eligible Medicare patients (min of 8 or 15 patients) via Registry or · 30 patients via Claims or Registry	Report on all measures in at least 1 MG for: · 50% eligible Medicare patients (min of 8 or 15 patients) via Claims · 80% eligible Medicare patients (min of 8 or 15 patients) via Registry or · 30 patients via Claims or Registry	Claims and registry: Report on all measures in at least 1 MG for: · 20 patients. A majority of patients (11 out of 20) must be Medicare Part B FFS patients.

Notes for Table 7: [a]Applicable Quality Percent is applied to estimated allowed charges for covered professional services furnished by the eligible professional in the applicable reporting period. [b]For 2013, Incentive payments made through PQRS are subject to the mandatory reductions in federal budgetary resources known as sequestration, required by the Budget Control Act of 2011. The American Taxpayer Relief Act of 2012 postponed sequestration for 2 months. As required by law, President Obama issued a sequestration order on March 1, 2013. Under these mandatory reductions, PQRS incentive payments made to eligible professionals and group practices will be reduced by 2%. [c]Minimums of 8 and 15 patients apply to 6-month and 12-month reporting periods, respectively. In general, eligible professionals had the option to report through any of these mechanisms using a 12 month option; in addition, there were also 6 month reporting options for 2010 (individual measures for both Claims and Registry as well as measures groups for both Claims and Registry), 2011 (individual measures for both Claims and Registry as well as measures groups for both claims and Registry), and 2012 (Registry measures groups only).

In 2010, the GPRO quality measures included four disease modules (coronary artery disease, diabetes mellitus, heart failure, and hypertension) and four preventive care measures for 26 total measures. In 2012, CMS expanded this set by adding three disease modules (care coordination, chronic obstructive pulmonary disease, and ischemic vascular disease), adding preventive measures, and retiring certain other measures, resulting in a total of 29 quality measures for GPROs to report in 2012. Large GPRO practices had to report a minimum of 411 patients per measure in the disease module and preventive care measure or all eligible patients if fewer were available; Small GPRO practices were required to report a minimum of 218 patients per disease module/measure or all eligible patients if fewer were available. Eligible Professionals participating in a Medicare ACO under the Shared Savings Program or Pioneer ACO Model were also required to submit data for a minimum of 411 patients for 22 quality measures established under the Shared Savings Program and Pioneer ACO Model (similar to Physician Quality Reporting System GPRO measures) via the web interface.

Incentive eligibility rules for the 2012 Physician Quality Reporting System remained relatively unchanged from 2011. The six-month reporting option was removed from all reporting mechanisms except for registry measures groups, which retained a six- and 12-month reporting

period for the 80 percent option in addition to a 12-month reporting option for 30 patients. Also, measures with a zero (0) percent performance rate were no longer counted toward requirements for satisfactory reporting for any individual reporting method; this also applied to inverse measures with a 100 percent performance rate. Individual eligible professionals who reported individual measures or measures groups through claims had to report at least 50 percent of eligible instances (for measures groups they also had the option to report on 30 patients). The Measures Applicability Validation (MAV) process continued, which determines if eligible professionals qualify for an incentive despite reporting fewer measures (e.g., less than three). As in prior years, the MAV was applied for eligible professionals who satisfied the reporting criteria (e.g., 50 percent for claims-based measures in 2012) for one or two individual measures and did not report other measures. The process determines whether they could have reported additional clinically-related measures through two tests. First, the clinical relation test checks for any eligible instances on measures related to those reported. Second, the minimum threshold test checks for a certain number of eligible instances for those measures the eligible professional could have reported based on the clinical relation test.[14] Eligible professionals who satisfied the reporting criteria for one or two individual measures but did not satisfy the MAV process did not earn an incentive because they could have reported additional measures. Conversely, eligible professionals who satisfied both the reporting criteria for one or two individual measures and the MAV process would qualify for an incentive.

Finally, as shown in Table 7, for eligible professionals who earned an incentive, the payment in the 2012 program year was one-half percent of total estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional in the applicable reporting period, compared to the quality percent of one percent that was applicable in 2011. The applicable quality percent will remain one-half percent for the 2013 program. Eligible professionals continued to have the opportunity to receive an additional incentive based on a quality percent of one-half percent in 2012 by participating in a MOCP and by meeting all of the following requirements:

- Satisfactorily report quality measures under the Physician Quality Reporting System, for a 12-month reporting period either individually or as part of a selected group practice, AND
- More frequently than is required to qualify for or maintain board certification, participate in a MOCP, AND
- More frequently than is required to qualify for or maintain board certification, successfully complete a qualified MOCP practice assessment.

B. Incentive Payments

The incentive for the 2012 Physician Quality Reporting System was equal to one-half percent of estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional (professional and technical services) during the applicable reporting period. We have included results for eligible professionals within ACOs reporting under the Medicare

[14] The threshold for eligible instances was 50 in 2007, 30 in 2008, 15 in 2009, 15 for the 12-month method and 8 for the 6-month method in both 2010 and 2011, and 15 in 2012.

Shared Savings Program and Pioneer ACO Model given that these ACOs may report through those programs for the sake of earning Physician Quality Reporting System incentives. Overall, a total of $167,815,193 in incentive payments (excluding additional MOCP incentive payments) were distributed to 367,228 eligible professionals for the 2012 program year, with an average payment of $457 (Table 5).[15] This includes incentives paid to 29,254 practices (including individually participating eligible professionals, summarized at the practice level, as well as practices that received an incentive under the Physician Quality Reporting System GPRO or eligible professionals that participated in an ACO under the Medicare Shared Savings Program or the Pioneer ACO Model), with an average incentive payment of $5,736 per practice for the 2012 program year. A total of $12,065,042 was paid to 66 practices qualifying for an incentive via the GPRO and $32,766,827 was paid to the 141 practices qualifying for an incentive as an ACO (Appendix Table A36). Average payments to these group reporting practices were larger than those to practices of individual participants; for example, the average practice-level incentive payment for Large GPRO was $203,041 compared to an average of $5,736 per incentive eligible practice overall.

As seen in Figure 1, the numbers of eligible professionals and practices earning incentives grew between 2007 and 2012. The average incentive payments increased from 2008 to 2010 but have since decreased due to the decrease in the applicable quality incentive percentage from two percent in 2010 to one percent in 2011 to one-half percent in 2012 (Table 7).

Incentive Payments by Specialty

Total incentive payments by specialty under the Physician Quality Reporting System are determined both by the number of eligible professionals within the specialty who qualify for an incentive and by total Part B MPFS allowed charges for covered professional services furnished by those eligible professionals during the applicable reporting period. Therefore, variations in total incentive payments by specialty reflect differences both in incentive eligibility rates (number of eligible professionals who received an incentive divided by the number of eligible professionals who participated) and in Part B MPFS allowed charges for covered professional services furnished by the eligible professionals during the applicable reporting period. Appendix Table A2 displays the distribution of incentive payments by specialty and shows that there was a wide range in average incentive payments across specialties from $7 for Certified Nurse Midwives to $2,157 for Radiation Oncologists.

Appendix Table A3 presents the average potential incentive that could have been earned if 100 percent of individual eligible professionals participated and qualified for an incentive during a 12-month reporting period. This was calculated by summing the total 2012 Part B MPFS allowed charges for covered professional services furnished during the 12-month reporting period by all individual eligible professionals who could have participated in 2012, dividing by the number of those individual eligible professionals, and taking one-half percent of this value. Overall, the average potential incentive was $353 for all specialties, but exceeded $1,000 for six specialties (Appendix Table A3).

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

Additional Incentive Payments for Participation in Maintenance of Certification Programs (MOCPs)

As in 2011, in 2012 eligible professionals who qualified for a Physician Quality Reporting System incentive based on a 12-month reporting period could earn an additional incentive of one-half percent of total Part B MPFS allowed charges by meeting reporting and participation requirements related to MOCPs. To be eligible for the additional incentive payment (referred to in this report as the MOCP incentive), incentive eligible professionals had to be a physician. For the purposes of this program, the term "physician" was limited to doctors of medicine; doctors of osteopathy; doctors of dental surgery or of dental medicine; doctors of podiatric medicine; doctors of optometry; or doctors of chiropractic. In 2012, 13 boards were qualified for the MOCP incentive, compared to seven boards in 2011. These boards collected and reported data to CMS on behalf of participating eligible professionals. Twenty-nine specialties earned MOCP incentives in 2012, compared to only eight in 2011.

Tables 8 and 9 show MOCP incentives earned by participation mechanism and specialty. In the 2012 program, 5,600 eligible professionals earned an MOCP incentive payment, compared to 1,099 eligible professionals in the 2011 program. Most eligible professionals earning an MOCP incentive payment qualified for an incentive through the claims reporting mechanism (Table 8). However, those earning an MOCP incentive as registry reporters earned a higher median incentive payment ($1,066) compared for claims reporters ($387). As seen in Table 9, the majority of eligible professionals earning an incentive payment were in emergency medicine (58 percent), followed by radiology (27 percent) and ophthalmology (three percent).

Table 8: Physician Quality Reporting System MOCP Incentive Amounts by Participation Mechanism or Option (2012)

Level and Mechanism/Option	Number Eligible for MOCP Incentive	MOCP Median Incentive Payment	MOCP Mean Incentive Payment	MOCP Total Incentive Payments
Eligible Professional Level	--	--	--	--
Claims	4,464	$387	$590	$2,631,983
Registry	477	$1,066	$2,001	$954,583
EHR	35	$897	$1,489	$52,118
Small GPRO	8	$212	$228	$1,825
Large GPRO	268	$254	$408	$109,308
MSSP ACO	212	$147	$512	$108,551
Pioneer ACO	236	$355	$514	$121,341
Total (Unduplicated)	5,600	$397	$675	$3,779,189
Practice Level	--	--	--	--
Claims	998	$881	$2,637	$2,631,983
Registry	196	$2,399	$4,870	$954,583
EHR	17	$1,496	$3,066	$52,118
Small GPRO	2	$913	$913	$1,825
Large GPRO	35	$435	$3,123	$109,308
MSSP ACO	34	$979	$3,193	$108,551
Pioneer ACO	22	$1,648	$5,516	$121,341
Total (Unduplicated)	1,261	$1,007	$2,997	$3,779,189

Table 9: Eligible Professional MOCP Incentive Amounts by Specialty for Individual Participation Options (2011 to 2012)

Specialty	Number of Eligible Professionals who Earned MOCP Incentive in 2011	Total MOCP Incentive Payments in 2011	Number of Eligible Professionals who Earned MOCP Incentive in 2012	Total MOCP Incentive Payments in 2012
MD/DO	--	--	--	--
Allergy/Immunology	0	$0	3	$897
Cardiology	0	$0	80	$178,739
Critical Care	0	$0	4	$885
Dermatology	35	$111,378	83	$255,750
Emergency Medicine	1	$534	3,267	$1,074,165
Endocrinology	0	$0	7	$4,795
Family Practice	0	$0	5	$2,330
Gastroenterology	0	$0	1	$712
General Practice	0	$0	11	$2,130
Geriatrics	0	$0	3	$2,123
Infectious Disease	0	$0	1	$202
Internal Medicine	8	$3,406	88	$76,002
Interventional Radiologist	60	$56,394	82	$85,605
Nephrology	0	$0	19	$41,324
Neurosurgery	0	$0	3	$1,854
Nuclear Medicine	4	$2,464	2	$1,495
Obstetrics/Gynecology	0	$0	4	$141
Oncology/Hematology	1	$2,780	5	$8,578
Ophthalmology	0	$0	115	$406,895
Other MD/DO	1	$17	3	$695
Pediatrics	0	$0	2	$278
Pulmonary Disease	0	$0	9	$17,353
Radiation Oncology	71	$518,156	59	$188,499
Radiologist	833	$754,672	1,510	$1,243,332
Rheumatology	0	$0	4	$5,205
Other Eligible Professionals	--	--	--	--
Agencies/Hospitals/Nursing and Treatment Facilities	0	$0	3	$255
Optometry	25	$12,797	45	$24,399
Other Eligible Professional	19	$84,006	132	$119,847
Podiatrist	31	$18,882	50	$34,703
Total (Unduplicated)	1,099	$1,570,682	5,600	$3,779,189

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

C. Participation[16]

How to Participate

CMS provides multiple resources on the Physician Quality Reporting System website to assist eligible professionals who choose to participate in the program. The *2012 Measure List and Implementation Guide* gave guidance on how to determine which measures to report, the reporting method, and claims-based reporting principles. CMS also provides Frequently Asked Questions (FAQ's) covering a wide range of topics regarding the program.

In 2012, there were nine individual participation options and two participation group options for submitting data to the Physician Quality Reporting System. Unless otherwise noted, each mechanism applied to a 12-month period from January 1 to December 31, 2012:

1. Claims-Based Individual Measures 12-months. Eligible professionals could report QDCs for 143 individual measures via claims. To qualify for an incentive, eligible professionals had to report on at least three measures (or, if fewer than three apply, one or two measures, subject to a MAV review as described above) for at least 50 percent of reporting opportunities.

2. Claims-Based Measures Groups 50 Percent of Patients 12-months. Eligible professionals could report on applicable measures within any of 12 measures groups available for claims reporting. To be incentive eligible, eligible professionals had to report all applicable measures for at least one measures group on at least 50 percent of their applicable Medicare Part B fee-for-services (FFS) patients; a minimum of 15 Medicare Part B FFS patients was required.

3. Claims-Based Measures Group – 30 Patients 12-month. Eligible professionals could report all applicable measures within any of the 12 measures groups available for claims reporting. To be incentive eligible, eligible professionals had to report all applicable measures for at least one measures group on at least 30 Medicare Part B FFS patients.

4. Registry-Based Reporting – Individual Measures 12-months. Eligible professionals could submit data on 208 measures through a qualified registry. To be incentive eligible, eligible professionals had to report on at least three measures and report each measure in at least 80 percent of their applicable Medicare Part B FFS patients.

5. Registry-Based reporting – Measures Group 80 Percent of Patients 12-months. Eligible professionals could submit data for 22 measures groups through a qualified registry. To be incentive eligible, eligible professionals had to report all applicable measures for at

[16] In some places we have included results related to the Medicare Shared Savings Program and the Pioneer ACO Model given that eligible professionals within ACOs may report through those programs/models for purposes of earning a Physician Quality Reporting System incentive. However, such eligible professionals participating in such initiatives outside the traditional Physician Quality Reporting System are subject to reporting, participation, and program requirements specific to the Shared Savings Program and Pioneer ACO Model. Unless otherwise indicated, the program requirements discussed below (i.e. reporting options, mechanisms, periods, criteria and measures, participation rules, etc.) generally pertain to the traditional Physician Quality Reporting System.

least one measures group on at least 80 percent of applicable Medicare Part B FFS patients seen during the reporting period; a minimum of 15 patients was required.

6. Registry-Based Reporting – Measures Groups 80 Percent of Patients 6-months. This option had the same reporting criteria as the preceding registry-based measures groups 80 percent option with the following two exceptions: a minimum of eight Medicare Part B FFS patients and a 6-month period from July 1 to December 31, 2012.

7. Registry-Based Reporting – Measures Groups 30 Patients 12-months. Eligible professionals could submit data through a qualified registry. To be incentive eligible, eligible professionals had to report all applicable measures for at least one measures group on at least 30 patients; patients could only be Medicare Part B FFS.

8. Electronic Health Records —Direct Submission. Eligible professionals could submit data directly through a qualified EHR product. To be incentive eligible, eligible professionals had to report at least three of 51 available EHR measures for at least 80 percent of applicable Medicare Part B FFS patients seen by the eligible professional. Alternatively, eligible professionals could align with the Medicare EHR Incentive Program by reporting all three EHR Incentive Program Core Measures (or, if the denominator for one or more of these is zero, report up to three EHR Incentive Program alternate core measures) AND report three additional measures available for the Medicare EHR Incentive Program.

9. Electronic Health Records – Data Submission Vendor. Eligible professionals could submit data through a qualified data submission vendor. To be incentive eligible, eligible professionals had to report at least three of 51 available EHR measures for at least 80 percent of applicable Medicare Part B FFS patients seen by the eligible professional. Alternatively, eligible professionals could align with the Medicare EHR Incentive Program by reporting all three EHR Incentive Program Core Measures (or, if the denominator for one or more of these is zero, report up to three EHR Incentive Program alternate core measures) AND report three additional measures available for the Medicare EHR Incentive Program.

10. Large GPRO. Large practices (100 or more eligible professionals) that self-nominated and were selected by CMS had to complete all applicable 29 measures in the GPRO web interface for a pre-populated patient sample of 411 patients.

11. Small GPRO. Smaller practices (25 to 99 eligible professionals) that self-nominated and were selected by CMS had to complete all applicable 29 measures in the GPRO web interface for a pre-populated patient sample of 218 patients.

In addition, practices participating in the MSSP or Pioneer ACO Model were required to submit quality measures via the GPRO web interface in order to participate in the Physician Quality Reporting System. ACO practices could earn a Physician Quality Reporting System incentive by reporting a minimum of 411 patients via the web interface, but they reported on 22 measures, which differed slightly from those reported under the GPRO: two care coordination, two CAD, six diabetes, one heart failure, one hypertension, two IVD, and eight preventive measures. For further information on earning an incentive in the Physician Quality Reporting System under the

Medicare Shared Savings Program or Pioneer ACO Model, CMS provides multiple resources on the ACO website.

Participation Results

In 2012, there were 1,201,362 professionals eligible to participate in the Physician Quality Reporting System, including 134,510 eligible professionals who were part of a group practice that self-nominated under the GPRO, as well as eligible professionals within a Medicare ACO participating under the Medicare Shared Savings Program or the Pioneer ACO Model (Appendix Table A4).[17] Appendix Table A5 presents characteristics of eligible professionals that were eligible to participate in the 2012 Physician Quality Reporting System. Most eligible professionals eligible for individual participation were in solo or relatively small practices and were in a primary care or other non-surgical specialty. Most eligible professionals eligible for group reporting (because their practice self-nominated) were in large practices (200 or more eligible professionals).

Appendix Table A6 presents the number of eligible professionals who could have participated in the Physician Quality Reporting System through any reporting option by specialty for the 2009 to 2012 program years. Internal Medicine and Family Practice had the largest number of eligible professionals who could have participated in the program in 2012 (over 100,000 each). Nurse practitioner and physician assistants also had large numbers eligible to participate (70,615 and 59,312, respectively). Almost all specialties have seen an increase in the number eligible to participate in the program.

As shown in Figure 4 in the Executive Summary, each year of program operation has seen growth in participation across all reporting options except for a decline in registry reporting from 2011 to 2012. Overall, 301,874 eligible professionals (28 percent of those eligible) participated individually in the 2012 Physician Quality Reporting System (Appendix Table A4). In addition, 44,056 eligible professionals within 66 practices participated under the GPRO and 89,941 eligible professionals within 144 ACOs participated under the Medicare Shared Services Program and the Pioneer ACO Model. Including those participating using group reporting options (with group reporting options referring to both the Physician Quality Reporting System GPRO and ACOs reporting under the Medicare Shared Savings Program and Pioneer ACO Model), the overall participation rate was 36.3 percent, and the total number participating increased 36 percent from 2011. Early data from the first half of 2013 show that the number of eligible professionals submitting data via the claims mechanism alone was already more than in 2012 (Figure 4).

Eligible professionals who chose to participate in the 2012 Physician Quality Reporting System using the registry or EHR-based reporting mechanisms contacted the CMS-qualified registries or EHR vendors listed in the posted CMS qualified lists.[18] In 2012, there were 64 qualified registries that could submit data on behalf of eligible professionals, 56 of which submitted quality measure information. There were 24 approved EHR products for those choosing Direct

[17] The Appendix provides definitions of program eligibility, program participation and incentive eligibility.

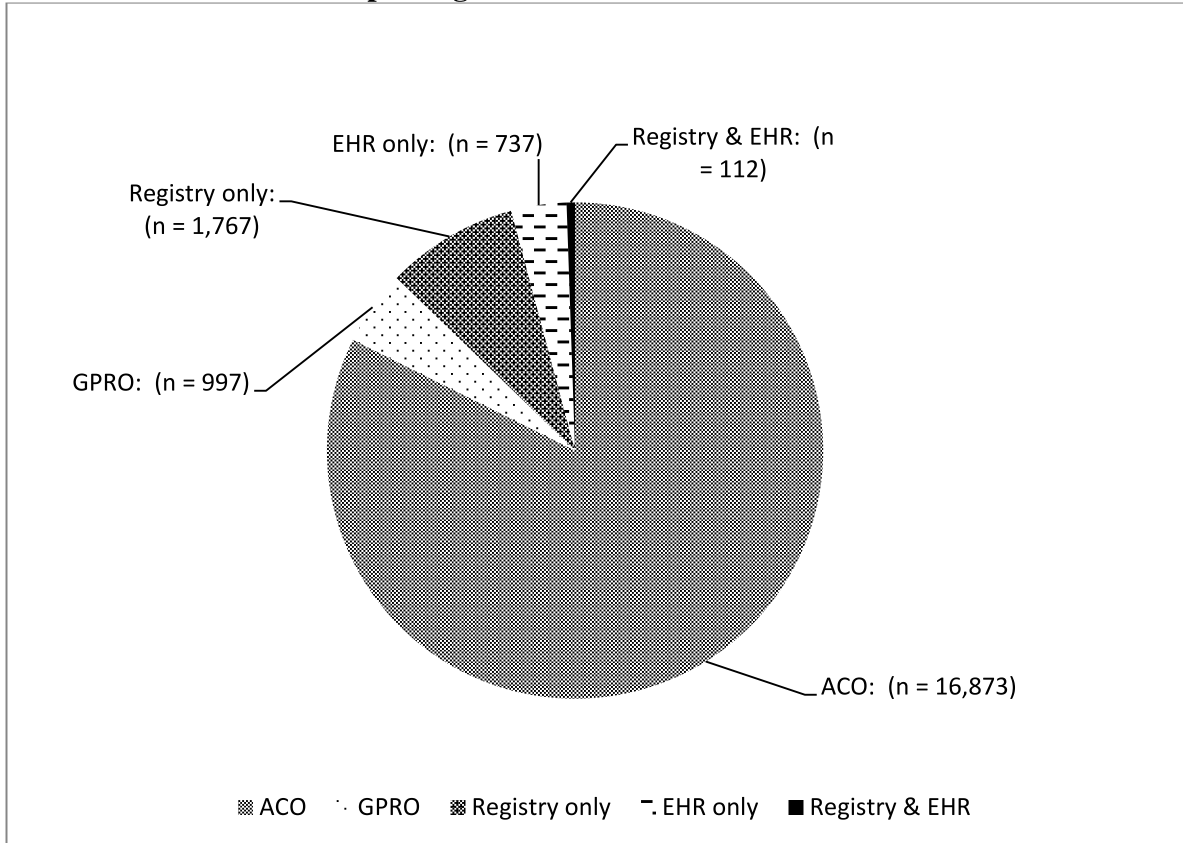
[18] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/2012_Physician_Quality_Reporting_System.html

EHR submission (of which 15 were used) and 53 approved EHR data submission vendors qualified by CMS to submit EHR data on behalf of participants (31 of these vendors submitted data).

Within the individual reporting option, 83 percent of participants used the claims mechanism (n=249,492), while 15 percent (n=46,642) used registry reporting, and nearly seven percent (n=19,817) participated via EHR (Appendix Table A4). Participation in the EHR option increased substantially (from 560) in 2011, while use of registry reporting (mostly individual measures) fell 25 percent from 2011. Most claims and registry participants participated via individual measures. Within the EHR mechanism, most participants participated via the new Data Submission Vendor option. About five percent of individual participants participated via more than one participation mechanism. Three percent of individual participants participated via claims and registry, one percent participated via claims and EHR, and 0.3 percent participated via registry and EHR (data not shown).

Most participants using the claims-reporting mechanism in 2012 had also used claims reporting in 2011. Among the 258,072 eligible professionals who participated in the program in both 2011 and 2012, 64 percent (n=165,809) used claims reporting in both years (including those who participated through more than one reporting mechanism), and 60 percent used claims reporting only in both years (data not shown). Figure 10 presents the distribution among the eight percent (n=20,486) of participants in both years that elected to report via claims in 2011, yet for 2012 they elected to report through different mechanisms for the purpose of earning a Physician Quality Reporting System incentive (i.e. through registry, EHR, or through the web interface as part of a practice that participated under the GPRO or within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model). Over four-fifths (82 percent) of these eligible professionals who used a mechanism other than claims in 2012 were within an ACO in 2012, followed by nine percent reporting via registry only, five percent under the Physician Quality Reporting System GPRO, four percent through EHR, and another one percent to using both registry and EHR.

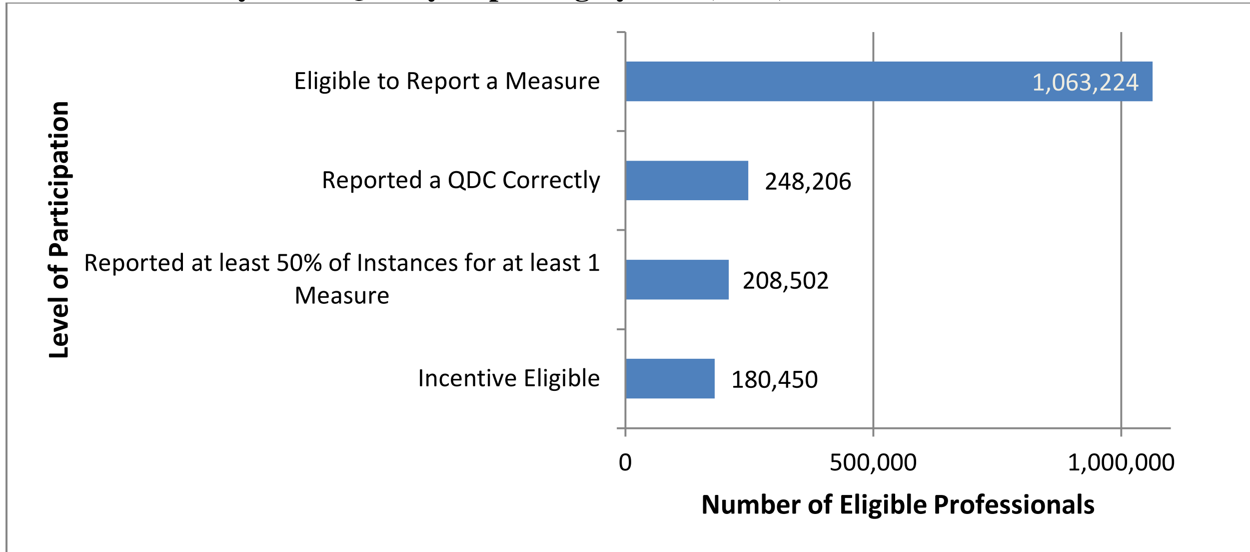
Figure 10. Reporting Mechanisms/Options Used in 2012 by Eligible Professionals Who Used Claims Reporting in 2011 but not in 2012



Notes for Figure 10: This chart represents the 20,486 eligible professionals that switched from claims reporting in 2011 to other forms of reporting in 2012.

Figure 11 summarizes participation through the claims-based individual measure reporting mechanisms in 2012. Over one million professionals were eligible to participate individually in the Physician Quality Reporting System in 2012, and almost one-quarter of these professionals participated by submitting at least one QDC without error via claims (23 percent). Among all eligible professionals attempting to submit a QDC (n=278,273), about four percent submitted all invalid QDCs (n=12,008) (data not shown). Ultimately, about 17 percent of professionals eligible to submit claims-based individual measures to the Physician Quality Reporting System qualified for an incentive in 2012. Incentive eligibility and payments are described in greater detail in subsequent sections of this report.

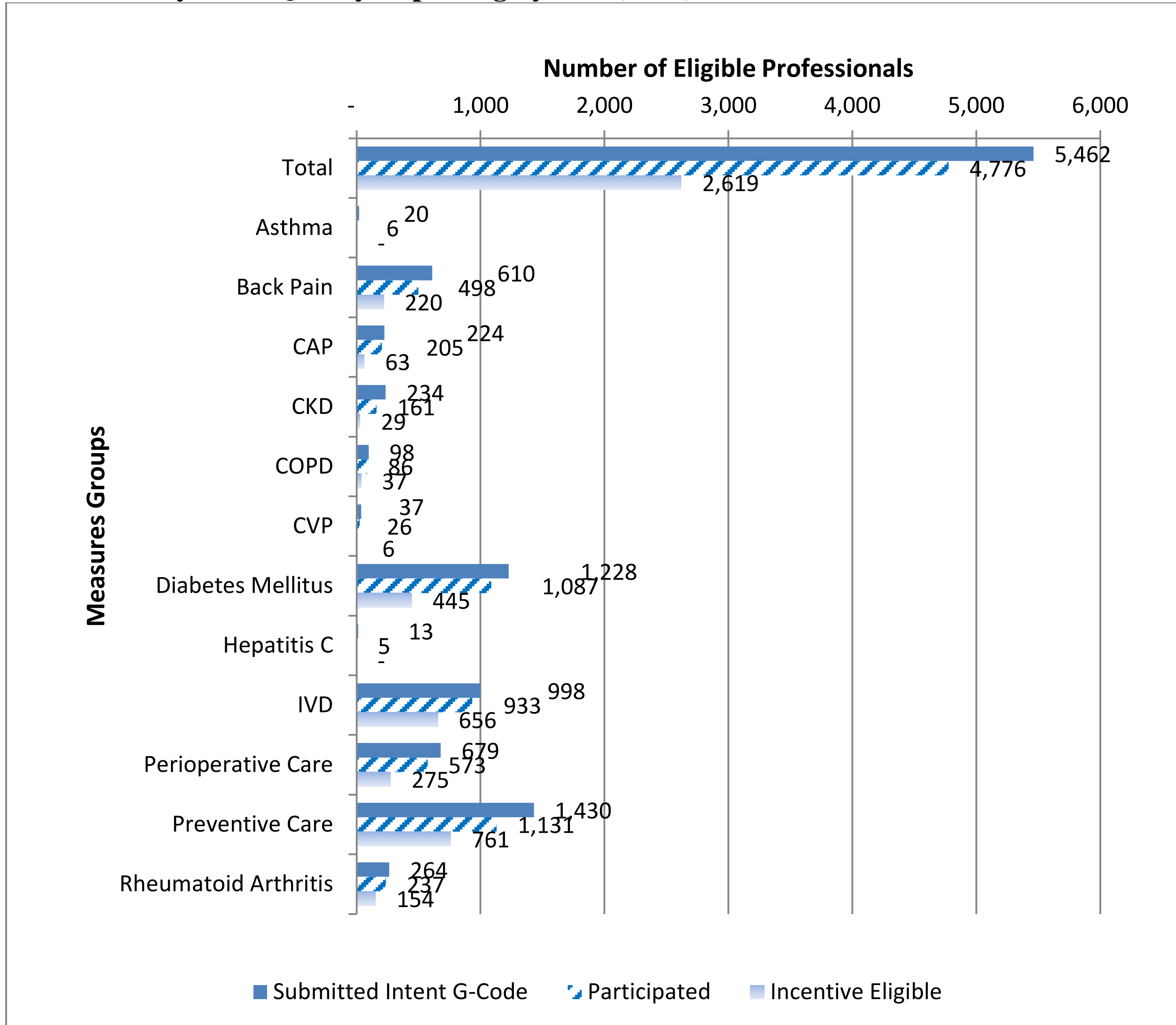
Figure 11: Summary of Individual Measures Reported through the Claims Mechanism for the Physician Quality Reporting System (2012)



Use of Measures Groups and Registries

The number of measures groups available for reporting under the Physician Quality Reporting System expanded from four to 22 between 2008 and 2012. The number of eligible professionals who participated via claims-based measures groups reporting mechanism grew modestly between 2009 and 2012 though this was still a very small proportion of claims-based reporting (Appendix Table A10). Claims-based measures group reporting was concentrated in family practice, internal medicine, cardiology, and orthopaedic surgery. Figure 12 shows the number of eligible professionals signaling their intention to participate in the claims-based measures group reporting option by submitting intent G-codes, submitting QDCs, and attaining incentive eligibility within each claims-based measures group. The preventive care measures group was reported the most by eligible professionals, followed by the diabetes and ischemic vascular disease (IVD) measures groups.

Figure 12: Summary of Measures Groups Reported through the Claims Mechanism for the Physician Quality Reporting System (2012)



Note for Figure 12: Results do not include data for eligible professionals who were part of a practice that participated under the GPRO or eligible professionals within and ACO that reported under the Medicare Shared Savings Program or Pioneer ACO Model.

Participation in the registry-based measures group reporting option was more common than participation through claims-based measures groups (10,478 eligible professionals using this option in 2012 compared to 4,776, respectively), though this still represented a minority of registry reporters (Appendix Table A12). The number of eligible professionals participating in registry measures groups peaked in 2010 at 17,133. Use of registry measures group reporting was concentrated within family practice, internal medicine, cardiology, and nephrology. These two measures groups are broadly applicable to the Medicare population and are applicable to two of the most common specialties (Family Medicine and Internal Medicine) reporting measures groups.

The number of registries submitting data on behalf of eligible professionals has also fluctuated over time. In 2008, 31 qualified registries submitted Physician Quality Reporting System data on

behalf of eligible professionals, compared to 87 in 2011 and 56 in 2012 (data not shown). Table 10 displays the registries that submitted data for the most eligible professionals in 2012; this reflects data from both the Physician Quality Reporting System and the eRx Incentive programs.[19] Some registries are more specific to a certain specialty and, therefore, might not have a high volume of eligible professionals to report measures via their registry.

Table 10: Registries that Submitted Data on Behalf of the Most Eligible Professionals for the Physician Quality Reporting System or the eRx Incentive Program (2012)

Registry Name	Eligible Professionals Submitted by Registry
NextGen_Registry	8,276
DocSite	6,235
GE Healthcare	4,296
Outcome(TM) PQRI Registry	3,540
CECity	3,238
Central Utah Informatics	2,805
MDinteractive	2,119
Ingenious Med, Inc.	2,103
IPC-The Hospitalist Company	1,731
NetHealth	1,706

Challenges to Participation and Satisfactory Reporting

The main challenges to satisfactory reporting in the Physician Quality Reporting System included: (1) failure to identify eligible patients or claims, (2) failure to submit QDCs for at least 50 percent of eligible instances (for claims reporting), and (3) QDC submission errors. For example, QDC submission errors encompass submitting a QDC on a claim that did not have a qualifying diagnosis or the appropriate patient age, or submitting the QDC on an incorrect Healthcare Common Procedure Coding System (HCPCS) code. For certain satisfactory reporting criteria, eligible professionals who submitted data for fewer than three claims-based individual measures also had to pass the MAV process to confirm they were eligible for fewer than three measures. About one-quarter of eligible professionals submitting claims data were subject to MAV in 2012 (data not shown).[20] In 2012, roughly five percent of those eligible professionals subject to the MAV process were not incentive eligible, which was less than one percent of all eligible professionals who participated.

[19] A complete listing of qualified registries available for the 2012 Physician Quality Reporting System can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2012-Qualified-Registries-Posting-Phase2.pdf.

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

CMS posts the rates of QDC errors on the Physician Quality Reporting System website.[21] These errors occurred when a QDC was submitted on a claim that did not have required information (e.g., diagnosis, procedures, and gender) for that measure. An invalid QDC could occur, for example, if an eligible professional submits a QDC on a claim that lacks the necessary combination of diagnosis and procedure codes to identify the measure denominator. Because ineligible claims are not included in the measures denominator, QDC errors do not adversely affect an eligible professional's reporting rate.[22] However, proactive monitoring and reporting of QDC errors can provide eligible professionals with information on the most common errors in reporting, which they can use to improve their chances of earning an incentive payment.

The most common QDC error was reporting a QDC on a claim that did not also have the required denominator eligible procedure code (HCPCS or CPT). Among 86,937,724 QDC submissions for all measures in 2012, nine percent were invalid: eight percent had an incorrect procedure code and/or an incorrect diagnosis code, one percent had an incorrect age and/or gender, and less than one-half of one percent were reported on instances with a missing procedure code (data not shown).[23]

Though most measures reported had low rates of QDC errors, some measures reported had relatively high QDC error rates. Appendix Tables A17 through A19 highlight measures with high rates (greater than 20 percent) of specific QDC errors. For example, 68 percent of QDCs reported for measure #122 (Chronic Kidney Disease [CKD]: Blood Pressure Management) had a mismatch between the QDC and the required diagnosis on the claim (Appendix Table A17). It is recommended that eligible professionals double check the measure specifications to ensure accurate submission, especially if they are submitting measures with higher rates of submission errors.

Some Physician Quality Reporting System participants who used a registry or EHR experienced submission problems. About 21 percent of registries submitted incorrect reporting rates based on the submitted numerators and denominators (data not shown). Almost 36 percent of registries submitted performance rates which did not equal rates calculated from the submitted numerator and denominator values. Finally, among registry measures group reporters, roughly one out of five had an eligible professional missing at least one measure within the measures group. The most common errors for EHR reporting were: invalid HIC numbers (14 percent of EHR reporters); the inclusion of TINs who were participating under the GPRO or within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model (ten percent); and TIN/NPIs without MPFS charges (6 percent) (data not shown).

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[21] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/.

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

[23] More detail on the frequency of specific QDC errors can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/4Q_2012_QDC_Error_Report_042213.pdf (note that results quoted in the text above include updated claims processing through February 2013 and will differ slightly from the 4th quarter report posted on the CMS website.

Participation by Specialty

Many measures in the Physician Quality Reporting System apply to emergency medicine and primary care, providing numerous opportunities for eligible professionals in these specialties to report on their Medicare patients.[24] As shown in Table 11, of eligible professionals who participated through claims-based individual measures reporting option, several hospital-based specialties were among the top ten specialties using this reporting mechanism.

For example, emergency physicians had the largest representation among all specialties and also had a high rate of participation in this mechanism (64 percent), followed by anesthesiology, which had the second highest number of participants and a 57 percent participation rate. Nurse anesthetist and radiology had the fourth and fifth highest number of participants in claims-based individual measures. Hospital-based practices most likely have processes in place to capture clinical data accurately, allowing quicker uptake of reporting quality measure data. Eligible professionals in the fields of internal medicine, family practice, and nurse practitioner also had a relatively large number of professionals who participated in the 2012 program (third, sixth, and eighth, respectively); however, these specialties had lower than average participation rates (17 to 21 percent). Appendix Table A8 shows eligibility and participation rates by specialty across all reporting options from 2009 to 2012. Participation rates by specialty and submission mechanism for 2009 through 2012 can be found in Appendix Tables A9 through A13.

Table 11: Specialties with the Largest Number of Eligible Professionals Participating in the Physician Quality Reporting System by Reporting Individual Measures through the Claims Mechanism (2012)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Emergency Medicine	52,617	33,880	64.4%
Anesthesiology	42,342	24,317	57.4%
Family Practice	87,971	18,745	21.3%
Nurse Anesthetist	45,554	18,669	41.0%
Radiologist	35,443	18,333	51.7%
Internal Medicine	86,014	17,477	20.3%
Physician Assistant	51,460	12,953	25.2%
Nurse Practitioner	61,076	10,136	16.6%
Optometry	33,252	9,969	30.0%
Physical/Occupational Therapy	46,597	9,246	19.8%

Note for Table 11: Results exclude eligible professionals who are part of a group practice that participated under the Physician Quality Reporting System GPRO or eligible professionals within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model.

The specialties with the largest number of eligible professionals who submitted data through the claims measures groups option are listed in Table 12. (Appendix Table A10 presents results for

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

all specialties.) As in 2011, family practice and internal medicine had the highest number of submissions of claims-based measures groups, though the overall participants in this method were relatively low.

Table 12: Specialties with the Largest Number of Eligible Professionals Participating in the Physician Quality Reporting System by Reporting Measures Groups through the Claims Mechanism (2012)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Family Practice	87,971	880	1.0%
Internal Medicine	86,014	823	1.0%
Cardiology	21,469	549	2.6%
Orthopaedic Surgery	20,037	381	1.9%
Nurse Practitioner	61,076	268	0.4%
Physical/Occupational Therapy	46,597	232	0.5%
Other Eligible Professional	40,963	202	0.5%
Rheumatology	3,882	188	4.8%
Physician Assistant	51,460	145	0.3%
Emergency Medicine	52,617	144	0.3%

Note for Table 12: Results exclude eligible professionals who are part of a group practice that participated under the Physician Quality Reporting System GPRO or eligible professionals within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model.

Internal medicine and family practice had the highest numbers of eligible professionals participating via the registry mechanism in 2012, followed by cardiology and nurse practitioner (Table 13). (See Appendix Table A11 and A12 for results for all specialties.) Relative to the number eligible, nephrology, dermatology, and cardiology had high rates of participation via registry (20, 17, and 15 percent, respectively).

Table 13: Specialties with the Largest Number of Eligible Professionals Participating in the Physician Quality Reporting System through the Registry Mechanism (2012)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Internal Medicine	86,014	7,362	8.6%
Family Practice	87,971	6,770	7.7%
Cardiology	21,469	3,175	14.8%
Nurse Practitioner	61,076	2,426	4.0%
Other Eligible Professional	40,963	1,898	4.6%
Physical/Occupational Therapy	46,597	1,772	3.8%
Physician Assistant	51,460	1,726	3.4%
Dermatology	10,076	1,708	17.0%
Nephrology	7,699	1,568	20.4%
Radiologist	35,443	1,542	4.4%

Note for Table 13: Results exclude eligible professionals who are part of a group practice that participated under the Physician Quality Reporting System GPRO or eligible professionals within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model.

Family practice, internal medicine, nurse practitioner, and cardiology were also the top four specialties using the EHR reporting mechanism in 2012 (Table 14). See Appendix Table A13 for more detail.

Table 14. Specialties with the Largest Number of Eligible Professionals Participating in the Physician Quality Reporting System through the EHR Mechanism (2012)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Family Practice	87,971	4,539	5.2%
Internal Medicine	86,014	3,215	3.7%
Nurse Practitioner	61,076	1,588	2.6%
Cardiology	21,469	1,560	7.3%
Physician Assistant	51,460	1,098	2.1%
Obstetrics/Gynecology	28,860	1,003	3.5%
General Surgery	20,783	660	3.2%
Other Eligible Professional	40,963	534	1.3%
Orthopaedic Surgery	20,037	528	2.6%
Neurology	11,606	422	3.6%

Note for Table 14: Results exclude eligible professionals who are part of a group practice that participated under the Physician Quality Reporting System GPRO or within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model.

Among eligible professionals who were part of practices participating through the Physician Quality Reporting System GPRO or eligible professionals within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model, the most common specialties were internal medicine, family practice, nurse practitioner, and physician assistant (Table 15).

Table 15. Specialties with the Largest Number of Eligible Professionals Participating through the Physician Quality Reporting System GPRO or within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model (2012)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Internal Medicine	19,929	19,906	99.9%
Family Practice	13,970	13,925	99.7%
Nurse Practitioner	9,539	9,442	99.0%
Physician Assistant	7,852	7,715	98.3%
Cardiology	5,365	5,362	99.9%
Radiologist	5,133	5,133	100.0%
Emergency Medicine	4,921	4,912	99.8%
Obstetrics/Gynecology	4,709	4,705	99.9%
Other Eligible Professional	4,086	4,083	99.9%
Anesthesiology	3,853	3,851	99.9%

Participation by Beneficiary Volume and Specialty

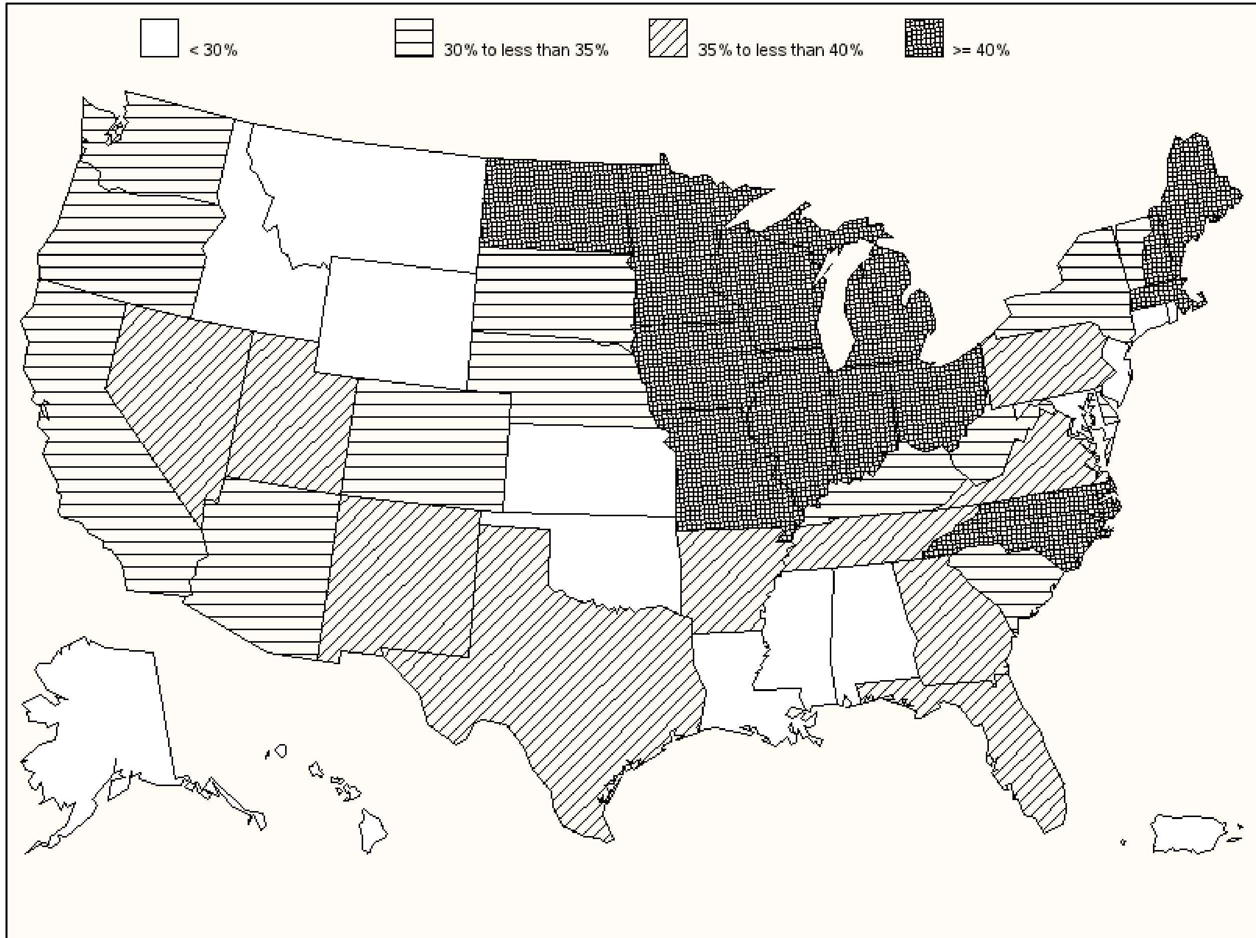
Participation rates among eligible professionals generally increased by beneficiary volume - defined as the number of beneficiaries who had an eligible claim for at least one Physician Quality Reporting System measure - but patterns varied by specialty. Among all specialties, eligible professionals with 25 or fewer patients had a participation rate of 19 percent, compared to 32 percent among those with 26 to 100 patients, 44 percent among those with 101 to 200 patients, and 52 percent among those with more than 200 patients. This general pattern was present for almost all specialties, especially MD/DOs and those with larger numbers of participants overall. Within family practice and internal medicine, the participation rate within the largest two beneficiary volume groups (more than 100 beneficiaries) was over twice the rate among eligible professionals treating fewer than 25 beneficiaries. Among emergency medicine, eligible professionals with larger beneficiary volumes had very high participation rates over 70 percent (Appendix Table A14).

Geographic Variation in Participation

Figure 13 demonstrates the geographic variation in participation rates for the 2012 Physician Quality Reporting System.[25] Detailed state-by-state participation results are available in Appendix Table A15. Participation was generally highest in states in the Northeast and Midwest. Participation rates were highest in Minnesota (52 percent), Wisconsin (51 percent) and Massachusetts and New Hampshire (both 50 percent). Participation was lowest (20 percent or lower) in Alaska, Puerto Rico, Virgin Islands, and Wyoming.

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

Figure 13: Geographic Distribution of Eligible Professionals Participating in the Physician Quality Reporting System (2012)



Notes for Figure 13: Results included all individual participation Physician Quality Reporting System mechanisms (i.e., claims, registry, and EHR) as well as eligible professionals who belong to a practice that participated under the Physician Quality Reporting System GPRO or eligible professionals within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model. The data used to populate this map can be found in Appendix Table A15.

Participation by Measure

Many measures in the Physician Quality Reporting System were selected because they were applicable to a wide range of eligible professionals and Medicare beneficiaries. The measures applicable to the largest number of eligible professionals were those related to use of Health Information Technology (HIT), pain assessment and follow-up, documentation of medications, and preventive care (Table 16).

Table 16: Individual Measures Reportable by the Largest Number of Eligible Professionals for the Physician Quality Reporting System (2012)

Measure Number	Measure Description	Eligible Professionals
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	748,413
131	Pain Assessment and Follow-Up	705,787
130	Documentation of Current Medications in the Medical Record	705,256
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	682,207
317	Preventive Care and Screening: Screening for High Blood Pressure	663,267
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	648,514
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	644,900
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	641,652
47	Advance Care Plan	618,360
154	Falls: Risk Assessment	589,962

Note for Table 16: Results include the claims, registry, and EHR mechanisms and exclude results for eligible professionals who are part of a practice that participated under the Physician Quality Reporting System GPRO or eligible professionals within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model.

Table 17 lists measures reported by the largest number of eligible professionals in 2012. While the top reported measures include four of the measures with the most eligible professionals able to report, they also include emergency medicine, perioperative care, and diabetes related measures. Although a large number of eligible professionals reported these measures, several measures were submitted by ten percent or fewer of those to which the measure was applicable, notably measure #124 (Adoption/Use of EHR), measure #226 (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention), measure #130 (Documentation of Current Medications in the Medical Record), and measure #111 (Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years or Older). Even though measure #124 was only reported by ten percent of eligible professionals, this measure may only be reported by those eligible professionals who have an EHR system as described in the measure. Appendix Table A16 displays the percentage of eligible professionals who reported each measure and the average reporting rate (total instances reported for a measure divided by total eligible instances for the measure) for each measure reported through claims.

Table 17: Measures Reported by the Largest Numbers of Eligible Professionals Under the Physician Quality Reporting System (2012)

Measure Number	Measure Description	Eligible Professionals Reporting the Measure	Percent of Eligible to Report the Measure
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	76,124	10.2%
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	63,072	9.7%
130	Documentation of Current Medications in the Medical Record	57,142	8.1%
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	45,226	8.1%
54	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	43,836	61.9%
30	Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics	43,553	52.6%
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	43,072	13.7%
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	42,358	13.4%
57	Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	42,050	21.9%
56	Emergency Medicine: Community-Acquired Pneumonia (CAP): Vital Signs	41,824	21.8%

Note for Table 17: Results include the claims, registry, and EHR mechanisms and exclude results for eligible professionals who are part of a practice that participated under the Physician Quality reporting System GPRO or eligible professionals within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model.

Table 18 presents information on the top five measures submitted by each specialty, identified by measure number. Overall, among eligible professionals with an MD/DO and in total, the top five measures reported in 2012 were: #124 (Adoption/Use of EHR), #226 (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention), #130 (Documentation of Current Medications in the Medical Record), #111 (Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years or Older), and #1 (Diabetes Mellitus: Hemoglobin A1c Poor Control). While #124 was also the top measure in 2011, the top measures in 2012 among MD/DOs include more preventive measures than in 2011.

Table 18: The Five Most Frequently Reported Individual Measures, by Specialty, for the Physician Quality Reporting System (2012)

Specialty	#1 (Top)	#2	#3	#4	#5
MD/DO	**124**	**226**	**130**	**111**	**1**
Allergy/Immunology	124	226	130	111	110
Anesthesiology	30	193	76	124	130
Cardiology	226	6	124	130	204
Colon/Rectal Surgery	124	20	113	23	226
Critical Care	226	124	111	47	76
Dermatology	137	224	138	124	226
Emergency Medicine	56	54	57	58	59
Endocrinology	1	3	2	124	226
Family Practice	1	3	2	226	111
Gastroenterology	124	113	130	226	128
General Practice	1	3	124	226	2
General Surgery	124	226	130	113	111
Geriatrics	1	111	3	124	2
Hand Surgery	124	130	226	39	111
Infectious Disease	124	111	110	130	226
Internal Medicine	1	3	2	124	111
Interventional Radiologist	145	195	76	10	147
Nephrology	124	3	226	130	110
Neurology	124	226	130	128	111
Neurosurgery	124	226	130	21	20
Nuclear Medicine	147	226	111	110	6
Obstetrics/Gynecology	226	124	112	130	39
Oncology/Hematology	124	70	69	226	72
Ophthalmology	14	12	117	18	140
Oral/Maxillofacial Surgery	226	124	128	130	111
Orthopaedic Surgery	124	21	23	226	20
Other MD/DO	47	31	32	36	124
Otolaryngology	124	226	130	111	110
Pathology	99	100	249	251	250
Pediatrics	124	130	226	110	1
Physical Medicine	124	130	226	111	128
Plastic Surgery	124	226	130	111	110
Psychiatry	124	226	130	107	9
Pulmonary Disease	226	124	111	110	130
Radiation Oncology	105	194	104	156	102
Radiologist	145	195	10	146	147
Rheumatology	124	108	226	39	130
Thoracic/Cardiac Surgery	43	44	45	21	226

Specialty	#1 (Top)	#2	#3	#4	#5
Urology	124	48	226	130	49
Vascular Surgery	124	226	21	130	22
Other Eligible Professionals	**124**	**130**	**30**	**226**	**193**
Agencies/Hospitals/Nursing and Treatment Facilities	47	124	3	1	56
Audiologist	130	124	190	261	134
Certified Nurse Midwives	124	226	130	112	128
Chiropractor	131	182	124	226	1
Clinical Nurse Specialists	124	226	130	1	2
Counselor/Psychologist	124	134	107	130	106
Dentist	124	130	226	111	110
Dietitian/Nutritionist	1	2	3	124	130
Nurse Anesthetist	30	193	76	124	130
Nurse Practitioner	124	226	130	1	111
Optometry	12	14	117	140	18
Other Eligible Professional	124	226	130	113	54
Physical/Occupational Therapy	131	154	130	155	128
Physician Assistant	54	56	57	58	124
Podiatrist	126	163	127	124	226
Registered Nurse	30	193	124	226	3
Social Worker	124	107	130	106	226
Unknown/Missing	124	30	117	130	226
Total	**124**	**226**	**130**	**111**	**1**

Note for Table 18: Please refer to the Appendix Table A1 for measure descriptions; results include claims, registry, and EHR mechanisms. Results do not include data for eligible professionals who belong to a practice that participates under the Physician Quality reporting System GPRO or eligible professionals within an ACO under the Medicare Shared Savings Program or Pioneer ACO Model.

D. Incentive Eligibility[26]

To qualify for an incentive under the Physician Quality Reporting System, eligible professionals must meet the criteria for satisfactory reporting applicable to the submission method and reporting period. An individual eligible professional was eligible for an incentive under the 2012 Physician Quality Reporting System if the eligible professional met one of the satisfactory

[26] In some places we have included results related to the Medicare Shared Savings Program and the Pioneer ACO Model given that eligible professionals within ACOs may report through those programs/models for purposes of earning a Physician Quality Reporting System incentive. However, such eligible professionals participating in such initiatives outside the traditional Physician Quality Reporting System are subject to reporting, participation, and program requirements specific to the Shared Savings Program and Pioneer ACO Model. Unless otherwise indicated, the program requirements discussed below (i.e. reporting options, mechanisms, periods, criteria and measures, participation rules, etc.) generally pertain to the traditional Physician Quality Reporting System.

reporting criteria applicable for at least one individual reporting option. The three basic criteria were:

- Percentage Method:
  - 50 percent of patients, individual measures option: An eligible professional must report at least 50 percent of eligible instances for at least three measures; this criterion applied to the individual measures option for the claims mechanism only. An eligible professional could qualify for an incentive by reporting at least 50 percent of eligible instances on one or two measures (i.e. less than three) if the MAV process was passed; the MAV process checked to ensure there were no other measures the eligible professional could have reported. Eligible professionals could report using this option for a 12-month period (January 1 through December 31, 2012).
  - 80 percent of patients, individual measures option: An eligible professional must report at least 80 percent of eligible instances for at least three measures; this criterion applied to the individual measures option for the registry and EHR reporting mechanisms. Eligible professionals could report using this option for a 12-month period (January 1 through December 31, 2012).
  - 50 percent of patients, measures groups option: An eligible professional must report all applicable measures for at least one measures group among the 12 available for claims reporting provided they reported for at least 50 percent of all applicable Medicare Part B PFS patients. They could report this option for a 12-month period (January 1 through December 31, 2012) for a minimum of 15 patients.
  - 80 percent of patients, measures groups option: An eligible professional must report all applicable measures for at least one measures group among the 22 available for registry reporting provided they reported for at least 80 percent of applicable Medicare Part B FFS patients. They could choose to report for a 12-month period (January 1 through December 31, 2012) for a minimum of 15 patients; they could also choose to report for a 6-month period (July 1 through December 31, 2012) for a minimum of eight patients.
- 30 Patient Method: An eligible professional must report at least one measures group for at least 30 patients; this criterion applied to the claims and registry mechanisms. The method required all Medicare Part B FFS patients for both claims- and registry-reporting. Participants using the 30-patient reporting criterion for the claims or registry reporting mechanisms were required to use a 12-month reporting period (January 1 through December 31, 2012).
- Align with EHR Meaningful Use: For EHR reporters choosing to align with the EHR Incentive Program (Meaningful Use), an eligible professional must report on all three Medicare EHR Incentive Program core measures (or, if the denominator for one or more of the Medicare EHR Incentive Program core measures is zero, the eligible professional must report on up to three Medicare EHR Incentive Program alternate core measures) AND report on three additional measures available for the Medicare EHR Incentive Program.

In addition to the incentive eligibility criteria listed above, measures submitted via any individual participation method with a performance rate of zero percent were not used to calculate incentive eligibility; inverse measures are an exception since a zero percent performance rate indicates the desired performance on these measures. Therefore, inverse measures with 100 percent performance rates were likewise not used to calculate incentive eligibility.

Practices participating via group reporting had to report on a minimum of 411 consecutively assigned Medicare beneficiaries (from a maximum patient sample of 616) per disease module (or preventive care measure) for Large GPRO and 218 for Small GPRO (from a maximum patient sample of 327); if a practice had fewer than the required number of patients who were eligible for the module, the practice was required to report on 100 percent of assigned beneficiaries. The consecutively assigned Medicare beneficiaries are selected from those for whom services were furnished during the 2012 reporting period (January 1, 2012 to December 31, 2012).

Eligible professionals meeting the requirements for satisfactory reporting qualified for an incentive payment equal to one-half percent of the estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional or group practice during the applicable reporting period in 2012. Additional detail about incentive eligibility is described in the Appendix.

Incentive Eligibility by Reporting Approach

More than eight out of ten eligible professionals who participated in the 2012 Physician Quality Reporting System qualified for an incentive (84 percent), a slight increase from 2011 (83 percent) but a large increase from earlier years (72 percent in 2010 and 57 percent in 2009) (Appendix Table A20). In the 2012 program, the percentage of eligible professionals who qualified for an incentive continued to vary by reporting option. Figure 8 shows the percentage of participants participating individually that qualified for an incentive payment was highest among EHR participants (94 percent) and registry participants (85 percent for registry individual measures and 86 percent for registry measures groups) and lowest among those participating via the claims-based mechanism (73 percent for individual claims and only 55 percent for claims measures groups). Among the group reporting options, all of the practices that participated under the Large and Small GPRO qualified for an incentive payment. Almost all eligible professionals reporting as part of a Medicare ACO under the Medicare Shared Savings Program or Pioneer ACO Model earned an incentive (Appendix Table A20).

Incentive Eligibility by Specialty

The specialties with the most eligible professionals who qualified for an incentive follow the same patterns as participation. Across all reporting options, internal medicine, emergency medicine, and family practice, had the largest number of eligible professionals who earned an incentive (Appendix Table A2). Appendix Tables A21 through A25 present the percentage of eligible professionals from each specialty who qualified for an incentive by program year for each individual reporting method. Tables 19 through 21 display the specialties with the most eligible professionals who earned an incentive for each reporting mechanism.

Among the specialties with the most eligible professionals who qualified for an incentive through the claims-based individual option, emergency medicine, anesthesiology, nurse

anesthetist, and physician assistants also had relatively high rates (80 percent or above) of incentive eligibility (Table 19). Family practice and internal medicine also had large numbers of eligible professionals earning an incentive via claims-based individual reporting, but relatively lower incentive eligibility rates (63 and 59 percent respectively).

As seen in Table 20, the number of incentive eligible professionals and incentive eligibility rates among the specialties that participated in the claims-based measures groups reporting options were lower than other reporting options; however, cardiologists had a relatively high proportion of eligible professionals who qualified for an incentive within this method (80 percent).

Table 19: Top 10 Specialties Earning a Physician Quality Reporting System Incentive – Claims-Based Individual Measures Reporting Option (2012)

Specialty	Eligible Professionals who Participated	Eligible Professionals who Qualified for an Incentive	Percent Who Qualified for an Incentive
Emergency Medicine	33,880	30,970	91.4%
Anesthesiology	24,317	19,464	80.0%
Nurse Anesthetist	18,669	15,032	80.5%
Radiologist	18,333	14,098	76.9%
Family Practice	18,745	11,751	62.7%
Physician Assistant	12,953	10,698	82.6%
Internal Medicine	17,477	10,307	59.0%
Nurse Practitioner	10,136	7,395	73.0%
Physical/Occupational Therapy	9,246	6,657	72.0%
Other Eligible Professional	8,596	6,189	72.0%

Table 20: Top 10 Specialties Earning a Physician Quality Reporting System Incentive – Claims-Based Measures Groups Reporting Option (2012)

Specialty	Eligible Professionals who Participated	Eligible Professionals Who Qualified for an Incentive	Percent Who Qualified for an Incentive
Internal Medicine	823	509	61.8%
Family Practice	880	466	53.0%
Cardiology	549	439	80.0%
Orthopaedic Surgery	381	226	59.3%
Nurse Practitioner	268	125	46.6%
Rheumatology	188	123	65.4%
Other Eligible Professional	202	110	54.5%
Physical/Occupational Therapy	232	65	28.0%
Emergency Medicine	144	58	40.3%
Physician Assistant	145	53	36.6%

The incentive eligibility rates for eligible professionals who used registry-based reporting were quite high among specialties with the most participants. Within these specialties, non-MD/DO based specialties had lower incentive eligibility rates than those observed for MD/DO-based specialties (Table 21).

As seen in Appendix Table A25, family practice and internal medicine had over 3,000 eligible professionals earning incentive payments under the EHR mechanism. Cardiology, nurse practitioners, and physician assistants also had over 1,000 eligible professionals earning an incentive under this mechanism.

Table 21: Top 10 Specialties Earning a Physician Quality Reporting System Incentive – Reporting via Registries (2012)

Specialty	Eligible Professionals who Participated	Eligible Professionals Who Qualified for an Incentive	Percent Who Qualified for an Incentive
Internal Medicine	7,362	6,208	84.3%
Family Practice	6,770	6,179	91.3%
Cardiology	3,175	2,960	93.2%
Nurse Practitioner	2,426	1,855	76.5%
Dermatology	1,708	1,667	97.6%
Other Eligible Professional	1,898	1,541	81.2%
Radiologist	1,542	1,459	94.6%
Physician Assistant	1,726	1,352	78.3%
Ophthalmology	1,411	1,336	94.7%
Physical/Occupational Therapy	1,772	1,303	73.5%

E. Clinical Performance Rates

Although the Physician Quality Reporting System focuses on reporting of quality data by eligible professionals, clinical performance rates that use quality data submitted through the program can also be used to make inferences about the quality of care provided to Medicare beneficiaries, and will be used to determine a Physician Value-Based Modifier beginning in 2015.

Eligible professionals reported data on recommended quality actions that were performed, not performed, or did not apply (i.e., exclusions) on eligible instances; this information is used in this report to describe eligible professionals' clinical performance on measures. The following hierarchy was applied if an eligible professional participated through more than one reporting mechanism: (1) EHR[27], (2) claims, and (3) registry. Applying the hierarchy ensured only one performance rate for each measure for an eligible professional would be included in results; information could not be combined across reporting methods. The methods used to calculate performance rates in this report vary from the performance rates used for determining the

[27] EHR performance rates of zero percent have been excluded.

Physician Value-Based Modifier; see the Data and Methods section in Appendix A for more information.

The report also presents data on trends in measure performance; however, multiple factors should be considered when interpreting trends in the performance information. For example, there have been many changes within the Physician Quality Reporting System across program years. As described above, the participation options have been changed and refined. Individual measures were added, removed, or in some cases their definitions have changed. Moreover, the eligible professionals who participated each year change. As a result, it is unclear the extent to which any observed changes in performance on the measures were real or artifacts of the aforementioned changes.

Nonetheless, this section of the report aims to describe clinical performance rates and trends.[28] The Appendix Tables A26 and A27 provide reporting and performance information across program years. Changes in reporting and performance rates should be interpreted with caution because they include modifications to the Physician Quality Reporting System, such as new reporting options and participation methods and growth in the number of participants. Appendix Tables A29 through A31 display performance information among eligible professionals reporting the same individual measure for multiple program years, so performance can be compared across a consistent eligible professional cohort. Appendix Table A28 shows the number of eligible professionals who consistently reported measures across successive program years. Appendix Tables A29 through A31 also provide total counts for eligible professionals who have reported a measure for each of the past four, three, or two years, respectively.

Tables 22 and 23 display the measures with the largest percentage point decline and improvement in performance between 2009 and 2012, among eligible professionals who reported the measure for all four years. While this approach attempts to account for changes in who participated, it does not account for other changes. For example, trends in reporting mechanisms—such as a growth in EHR reporting or a measure changing to/from registry reporting only—could cause performance rates to change. Other examples of changes to measures include the addition of new exclusions or changes in thresholds used to define clinical control of a condition. Registries, in some cases, incorporate processes that support eligible professionals' selection of appropriate measures, edits that help to ensure that measures are submitted accurately, and reminders that help providers meet the performance criteria of the measures. In addition, performance rates may be less stable among measures with smaller samples, as is the case with a number of the measures in the following tables. The decrease in performance rates shown in Table 22 are generally linked to major revisions for the measures, usually several components, therefore impacting the eligible professionals and registries that were reporting. The top five measures, found in Table 23, generally had a gradual increase throughout the Physician Quality Reporting System program years 2009 to 2012; these measures appeared to remain stable for the four program years analyzed and they did not receive any major revisions which could be determined to mean that with practice in reporting the eligible professionals and registries performed better throughout the program years.

[28] Please see the Appendix for further description of performance rate calculations.

Table 22: Individual Measures Reported with the Largest Percentage Point Decrease in Clinical Performance Rate for the Physician Quality Reporting System (2009 to 2012)

Measure Number	Measure Description	2009 Performance Rate	2012 Performance Rate	Number of Eligible Professionals Reporting the Measure in each year from 2009 to 2012	Percentage Point Change 2009-2012
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	100.0%	45.9%	29	-54.1%
144	Oncology: Medical and Radiation – Plan of Care for Pain	98.8%	68.5%	4	-30.3%
123	Adult Kidney Disease: Patients On Erythropoiesis-Stimulating Agent (ESA) - Hemoglobin Level > 12.0 g/dL	98.5%	22.7%	107	-21.1%
121	Adult Kidney Disease: Laboratory Testing (Lipid Profile)	84.6%	65.6%	138	-18.9%
64	Asthma: Assessment of Asthma Control	82.6%	67.2%	23	-15.4%

Note for Table 22: Results included the claims, registry, and EHR reporting mechanisms. Results are restricted to a group of eligible professionals who reported the same measure from 2009 to 2012. This table includes measure performance regardless of whether eligible professionals reporting the measure met the satisfactory reporting requirements or not.

Table 23: Individual Measures Reported with the Largest Percentage Point Increase in Clinical Performance Rate for the Physician Quality Reporting System (2009 and 2012)

Measure Number	Measure Description	2009 Performance Rate	2012 Performance Rate	Number of Eligible Professionals Reporting the Measure in each year from 2009 to 2012	Percentage Point Change 2009-2012
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use	10.0%	50.0%	6	40.0%
181	Elder Maltreatment Screen and Follow-Up Plan	66.7%	98.7%	3	32.0%
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	60.2%	84.7%	145	24.5%
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients	70.2%	92.0%	134	21.8%
173	Preventive Care and Screening: Unhealthy Alcohol Use – Screening	69.9%	89.1%	223	19.2%

Notes for Table 23: Results included the claims, registry, and EHR reporting mechanisms. Results were restricted to a group of eligible professionals who reported the same measure from 2009 to 2012. This table includes measure performance regardless of whether eligible professionals who reported the measure met the satisfactory reporting requirement.

For some measures, improvement in measure performance over time was limited by measure performance that ‘topped out.’ In other words, if performance is at or near 100 percent, the ability to improve performance is limited. Table 24 displays the measures with the highest mean clinical performance rates in 2012.

Table 24: Individual Measures Reported with the Highest Mean Clinical Performance Rates for the Physician Quality Reporting System (2012)

Measure Number	Measure Description	Mean Performance Rate	Number of Eligible Professionals Submitting
304	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery	100.0%	12
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	99.9%	507
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	99.7%	76,124
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	99.3%	63
224	Melanoma: Overutilization of Imaging Studies in Melanoma	99.2%	1,914
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy	99.2%	785
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	99.2%	1,258
250	Radical Prostatectomy Pathology Reporting	99.1%	2,155
146	Radiology: Inappropriate Use of “Probably Benign” Assessment Category in Mammography Screening*	0.9%	9,606
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	98.9%	829

*Note for Table 24: Results include the claims, registry, and EHR reporting mechanisms. In total, there were 10 measures with performance rates of 100% in 2012, but most of these had fewer than 10 eligible professionals submitting. We have limited data in this table to results for measures that were reported by at least 10 eligible professionals. *Measure #146 was an inverse measure where a lower performance rate indicated better performance.*

Some measures show particularly high rates of performance across all eligible professionals. Table 25 displays measures for which at least 90 percent of the eligible professionals who reported the measure achieved performance at or above 90 percent in 2012. Appendix Table A32 is similar and displays the percent of eligible professionals who reported a measure and had a performance rate at or above 90 percent by individual measure.

Table 25: Individual Measures where at least 90 Percent of Eligible Professionals who Participated had at least a 90 Percent Performance Rate on the Physician Quality Reporting System Measure (2012)

Measure Number	Measure Description	Percent of Eligible Professionals with At Least 90% Performance Rate
82	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute	100.0%
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration	100.0%
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	100.0%
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	100.0%
171	Coronary Artery Bypass Graft (CABG): Anti-Lipid Treatment at Discharge	100.0%
213	Functional Communication Measure - Reading	100.0%
233	Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection	100.0%
234	Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)	100.0%
304	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery	100.0%
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	99.8%
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	99.7%
146	Radiology: Inappropriate Use of “Probably Benign” Assessment Category in Mammography Screening	99.1%
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	98.4%
263	Preoperative Diagnosis of Breast Cancer	97.8%
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	97.8%
224	Melanoma: Overutilization of Imaging Studies in Melanoma	97.5%

Measure Number	Measure Description	Percent of Eligible Professionals with At Least 90% Performance Rate
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	96.9%
247	Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence	95.9%
249	Barrett's Esophagus	95.8%
192	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	95.2%
250	Radical Prostatectomy Pathology Reporting	95.1%
58	Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Mental Status	94.9%
262	Image Confirmation of Successful Excision of Image–Localized Breast Lesion	94.8%
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy	94.8%
137	Melanoma: Continuity of Care – Recall System	93.9%
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	93.6%
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	93.3%
56	Emergency Medicine: Community-Acquired Pneumonia (CAP): Vital Signs	93.1%
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	92.6%
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	92.6%
156	Oncology: Radiation Dose Limits to Normal Tissues	92.5%
46	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	92.4%
267	Epilepsy: Documentation of Etiology of Epilepsy or Epilepsy Syndrome	91.9%
55	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Syncope	91.3%

Measure Number	Measure Description	Percent of Eligible Professionals with At Least 90% Performance Rate
57	Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	91.0%
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician	90.9%
266	Epilepsy: Seizure Type(s) and Current Seizure Frequency(ies)	90.8%
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	90.7%
186	Chronic Wound Care: Use of Compression System in Patients with Venous Ulcers	90.3%
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	90.3%
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	90.1%

Note for Table 25: Results include the claims, registry, and EHR reporting mechanisms. This table includes measure performance for eligible professionals regardless of whether the eligible professional met the satisfactory reporting requirement.

Group practices reporting under the Small or Large GPRO reported 29 measures covering care coordination/patient safety, chronic obstructive pulmonary disease, coronary artery disease, diabetes mellitus, heart failure, hypertension, ischemic vascular disease, and preventive care. Eligible professionals participating in Medicare ACOs under the Medicare Shared Savings Program or Pioneer ACO Model also reported results for a similar set of 22 measures in 2012. Appendix Table A33 through A35 summarize quality measure reporting and performance of the practices participating in the 2012 program through the Small and Large GPRO and ACO, respectively.

Practices under the Large GPRO (Appendix Table A34) reported measures for, on average, over 400 eligible assigned beneficiaries (denominator instances); a few measures were reported for fewer beneficiaries on average. The measures reported for the most eligible assigned beneficiaries, on average, were primarily for prevention and hypertension measures. Measure Performance rates among practices under Large GPRO ranged from a low of 45 percent for "Care-2: Falls-Screening for Future Fall Risk" quality measure to a high of 95 percent for the new "COPD-1: Bronchodilator Control" quality measure. Performance varied within modules; for example the preventive measures for tobacco use screening and cessation intervention and screening for high blood pressure had relative high performance rates (87 and 80 percent, respectively), compared to the other preventive measures which all had rates of 67 percent or below.

IV. ELECTRONIC PRESCRIBING (ERX) INCENTIVE PROGRAM

A. Background

Program Description

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

Under the eRx Incentive Program, eligible professionals report data on the electronic prescribing quality measure to describe their use of a qualified eRx system during an eligible visit with a Medicare beneficiary. As defined under the electronic prescribing quality measure, a qualified eRx system is one that is capable of all of the following:[29]

- 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.[30]
- Provide information related to lower cost and therapeutically appropriate alternatives (if any).
- Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available).

In addition, the system must employ, for the capabilities listed, the e-prescribing standards adopted by the Secretary for Part D. Individual eligible professionals did not need to participate in the Physician Quality Reporting System to participate in the eRx Incentive Program.

In 2012, the definition of a qualified eRx system was expanded to include electronic health record systems that are certified by an authorized testing and certification body recognized by the Office of the National Coordinator for Health Information Technology.

To participate in the eRx Incentive Program, eligible professionals could report data on the eRx quality measure on eligible Medicare Part B claims indicating a qualified eRx system was used. Beginning in 2010, individual eligible professionals also could submit data through a qualified registry or a qualified EHR vendor to indicate use of a qualified eRx system. Also beginning in 2010, group practices were eligible to report data on the eRx quality measure under the GPRO if they self-nominated to report the eRx quality measure as a group and were also approved to

[29] The eRx measure specification can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive.

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

participate in the Physician Quality Reporting System as a group; the claims, registry, and EHR reporting mechanisms were available. In 2011, the GPRO option for practices with 200 or more eligible professionals was referred to as GPRO I. Smaller group practices (ranging from 2 to 199 eligible professionals) were also eligible to participate under the option referred to as GPRO II. The GPRO II option in 2011 was divided into tiers depending on the number of eligible professionals within the practice: Tier 1 (2-10), Tier 2 (11-25), Tier 3 (26-50), Tier 4 (51-100), and Tier 5 (101-199). The reporting mechanisms available for the GPRO in program year 2011 remained unchanged from 2010 (claims, registry, and EHR). In 2012, the GPRO was refined to include Large GPRO (100 or more eligible professionals) and Small GPRO (25 to 99 eligible professionals). For program year 2012, eRx data could be reported through the claims, registry, and EHR reporting mechanisms. The 2013 eRx Incentive Program GPRO includes Large GPRO (100 or more eligible professionals), Medium GPRO (25 to 99 eligible professionals), and Small GPRO (2 to 24 eligible professionals); claims, registry, and EHR reporting were available.

To participate in the 2012 eRx Incentive Program under the claims submission method, eligible professionals reported a QDC, also known as a G-code, for the eRx quality measure on a Part B MPFS claim for an "eligible instance." Eligible instances are instances when the measure was applicable, as determined based on the presence of a specific set of procedure codes on a claim.[31] There was one valid QDC for the eRx quality measure in 2012:

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

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

To earn the incentive payment for the 2012 eRx Incentive Program, there were two criteria:

1. **Be a Successful Electronic Prescriber.** Individual eligible professionals had to report the eRx measure for at least 25 visits (eligible instances) during the reporting period. For practices participating through the GPRO, the number of reported instances required was 2,500 for Large GPRO and 625 for Small GPRO.

2. **10 Percent Limitation Threshold.** During the reporting period, the allowed charges for Medicare Part B covered professional services furnished by the eligible professional for the codes that appear in the eRx quality measure denominator must comprise at least 10 percent of the total allowed Part B MPFS charges for all such covered professional services furnished by the eligible professional. The same requirement applied to group practices that participated through the GPRO under the eRx Incentive Program.

The 2012 eRx Incentive Program incentive remained equal to one percent of total estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional or practice during the reporting period.

[31] 2012 denominator codes (CPT/HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, and G0109.

For 2012, there were 99,796 eligible professionals who participated individually in the eRx Incentive Program and who were incentive eligible, but who received an incentive through the Medicare EHR Incentive Program.[32] The total eRx incentive amount for these eligible professionals would have been $179,131,253 (more than half of total payments for the eRx Incentive Program). There were 66 group practices with 14,080 eligible professionals participating in the Medicare EHR Incentive Program; 14,011 were incentive eligible, accounting for total eRx Incentive Program GPRO incentive payments of $10,873,382.

Program Evolution

CMS did not make any changes to the reporting requirements for the eRx Incentive Program for individual eligible professionals for the 2012 program (see Table 26). As noted above, CMS refined the group reporting option to include Large GPRO (practices with 100 or more eligible professionals) and Small GPRO (practices with 25 to 99 eligible professionals).

Table 26 summarizes changes in the eRx Incentive Program rules from 2011 to 2013. The main changes over this period were the introduction and refinement of options for reporting under the GPRO, and a reduction in the applicable incentive percentage.

Table 26: Summary of eRx Incentive Program Requirements (2011 to 2013)

Statistic	2011	2012	2013
Applicable Percent [a]	1% of Part B MPFS allowed charges	1% of Part B MPFS allowed charges	0.5% of Part B MPFS allowed charges[b]
Reporting Mechanisms available to Individual eligible professionals and group practices	Claims, Registry, EHR	Claims, Registry[c], EHR[c]	Claims, Registry[c], EHR[c]
Participation Options	Individual Eligible Professionals, Group Practices I (GPRO I), Group Practices II (GPRO II)	Individual Eligible Professionals, Small Group Practices (Small GPRO), Large Group Practices (Large GPRO)[c]	Individual Eligible Professionals, Small Group Practices (Small GPRO), Medium Group practices (Medium GPRO), Large Group Practices (Large GPRO)[c]
Quality-Data Code(s)	G8553	G8553	G8553
Successful Electronic Prescriber Reporting Requirement for Individual Participation	At least 25 eligible events	At least 25 eligible events	At least 25 eligible events

[32] Eligible professionals can only receive one incentive from either the e-Prescribing Incentive Program or the EHR Incentive Program in a given program year.

Statistic	2011	2012	2013
Successful Electronic Prescriber Reporting Requirement for Group Practice Reporting Option (GPRO)	**GPRO I**: At least 2,500 eligible events **GPRO II**: requirement varied by number of eligible professionals per practice: 2 to 10 (75 events) 11 to 25 (225 events) 26 to 50 (475 events) 51 to 100 (925 events) 101 to 199 (1,875 events)	**Small GPRO**: At least 625 eligible events **Large GPRO**: At least 2,500 eligible events	**Small GPRO**: At least 75 eligible events **Medium GPRO**: At least 625 eligible events **Large GPRO**: At least 2,500 eligible events
Limitation Threshold	10% of Part B MPFS charges	10% of Part B MPFS charges	10% of Part B MPFS charges

Notes for Table 26:
[a] Applicable Quality Percent for the eRx Incentive Program is applied to estimated allowed charges for covered professional services furnished by the eligible professional in the applicable reporting period.
[b] For 2013, Incentive payments made through eRx are subject to the mandatory reductions in federal budgetary resources known as sequestration, required by the Budget Control Act of 2011. The American Taxpayer Relief Act of 2012 postponed sequestration for 2 months. As required by law, President Obama issued a sequestration order on March 1, 2013. Under these mandatory reductions, eRx incentive payments made to eligible professionals and group practices will be reduced by 2%. [c] Only registries and EHR vendors that qualify may submit data on behalf of eligible professionals, and group practices qualified for the Physician Quality Reporting System GPRO in the given year may participate.

B. Incentive Payments

In 2012, 227,447 eligible professionals (representing 55,015 practices) earned $335,331,216 in incentive payments (including eligible professionals who are part of a group practice that was incentive eligible under the GPRO and eligible professionals receiving their incentive under the Medicare EHR Incentive Program) (Table 5).[33] The average incentive payment was $1,474 per eligible professional and $6,095 per practice (Table 27).

Table 27: eRx Incentive Payment (2010 to 2012)

Incentive Description	2010	2011	2012
Average Incentive Payment per Eligible Professional	$3,263	$1,636	$1,474
Average Incentive Payment per Practice	$14,459	$6,598	$6,095
Total Incentive Amounts	$270,895,540	$285,049,103	$335,331,216

Notes for Table 27: Results include eligible professionals who were part of a practice that participated under the GPRO.

Appendix Table A37 presents the distribution of eRx Incentive Program payments by specialty in 2012. The majority of 2012 incentive payments were paid to the top participating specialties -

[33] Figures include 99,796 individually participating eligible professionals who were incentive eligible and received an incentive through the Medicare EHR Incentive Program.

internal medicine, cardiology, ophthalmology, and family practice. Appendix Table A38 shows the average potential incentive by specialty (based on one percent of estimated total Part B MPFS allowed charges for covered professional services furnished by eligible professionals during the reporting period) and the participation rate.

C. Participation

Participation Findings

The 2012 eRx Incentive Program consisted of one measure and one reporting period (January 1 through December 31, 2012). Individual eligible professionals did not have to enroll or file any intent to participate in the eRx Incentive Program. Overall, 778,904 eligible professionals could have participated in the eRx Incentive Program in 2012 compared to 748,224 in 2011. In addition, there were 225,109 eligible practices in 2012; 78,646 of these practices participated (Table 5).

Eligible professionals who chose to participate in the 2012 eRx Incentive Program using the registry or EHR-based reporting mechanisms contacted the CMS-qualified registries or EHR vendors listed in the posted CMS qualified lists.[34] In 2012, there were 38 qualified registries, 26 of which submitted eRx quality measure information. There were 16 EHR products approved for direct submission (six of which were used) and 40 EHR vendors qualified by CMS to submit EHR data (15 of which submitted data) (data not shown).

Overall, 344,676 eligible professionals (44 percent of those eligible) participated individually or as part of a group practice in the 2012 eRx Incentive Program (Figure 5), which was 22 percent increase from the total number of participants in 2011. Most of the increase in individual participants was through claims-based reporting, although the greatest percent increase within a reporting mechanism was for EHR. Within group reporting, 66 practices (out of 69 selected by CMS to participate), including 46,738 eligible professionals, participated in the eRx Incentive Program under the GPRO (Table A41).

Although results for 2013 were incomplete at the time this report was prepared, by June 2013, 246,177 individual eligible professionals submitted data for the eRx measure through claims (Figure 5). In addition, based on a preliminary list of practices intending to report under the GPRO for 2013, data for the eRx quality measure were submitted by 112 Large group practices (practices with 100 or more eligible professionals), 33 Medium group practices (25 to 99 eligible professionals) and 92 Small group practices (from two to 24 eligible professionals). Results for registry and EHR submissions were not yet available at the time this report was created.

In 2012, eligible professionals submitted a total of 29,211,774 eRx QDCs through claims, with an average of 100 QDCs submitted per eligible professional (not including GPROs; data not shown). Nearly all (95 percent) of these QDCs were correctly submitted. QDCs were rejected, for example, when an eligible professional used an incorrect procedure code (i.e., HCPCS/CPT code). Among registry reporters, registry data for 340 eligible professionals showed counts of 25

[34] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/2012-Electronic-Prescribing-Incentive-Program.html

or more eRx instances; however, claims data for these eligible professionals showed less than 25 eligible instances.

MD/DO practitioners were more likely than other types of eligible professionals to participate in the eRx Incentive Program in 2012 (Table 28). Over one-half (51 percent) of MD/DOs participated while less than one third of eligible professionals (31 percent) in the "other eligible professionals" category participated. This pattern may be due partly to the fact that many non-MD/DO practitioners would not report an e-prescribing measure under this program given the scope of their health care provider license.

Table 28: Number of Eligible Professionals Participating in the eRx Incentive Program by Specialty Category (2012)

Type of Eligible Professional	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
MD/DO	515,904	264,114	51.2%
Other Eligible Professionals	262,215	80,379	30.7%
Unknown/Missing	785	183	23.3%
Total (Unduplicated)	778,904	344,676	44.3%

Notes for Table 28: Results include eligible professionals who were part of a practice that participated under the GPRO.

Certain specialties were more likely to participate in the 2012 eRx Incentive Program than others (Table 29). Family practice and internal medicine had the largest number of eligible and participating professionals. Appendix Table A39 presents participation results for all specialties.

Table 29: Specialties with the Highest Participation in the eRx Incentive Program (2012)

Specialty	Eligible Professionals	Eligible Professionals who Participated	Percent of Eligible Professionals who Participated
Specialties with highest counts	--	--	--
Family Practice	91,318	54,596	59.8%
Internal Medicine	82,948	47,454	57.2%
Nurse Practitioner	59,913	27,057	45.2%
Physician Assistant	39,048	18,107	46.4%
Cardiology	24,382	17,856	73.2%

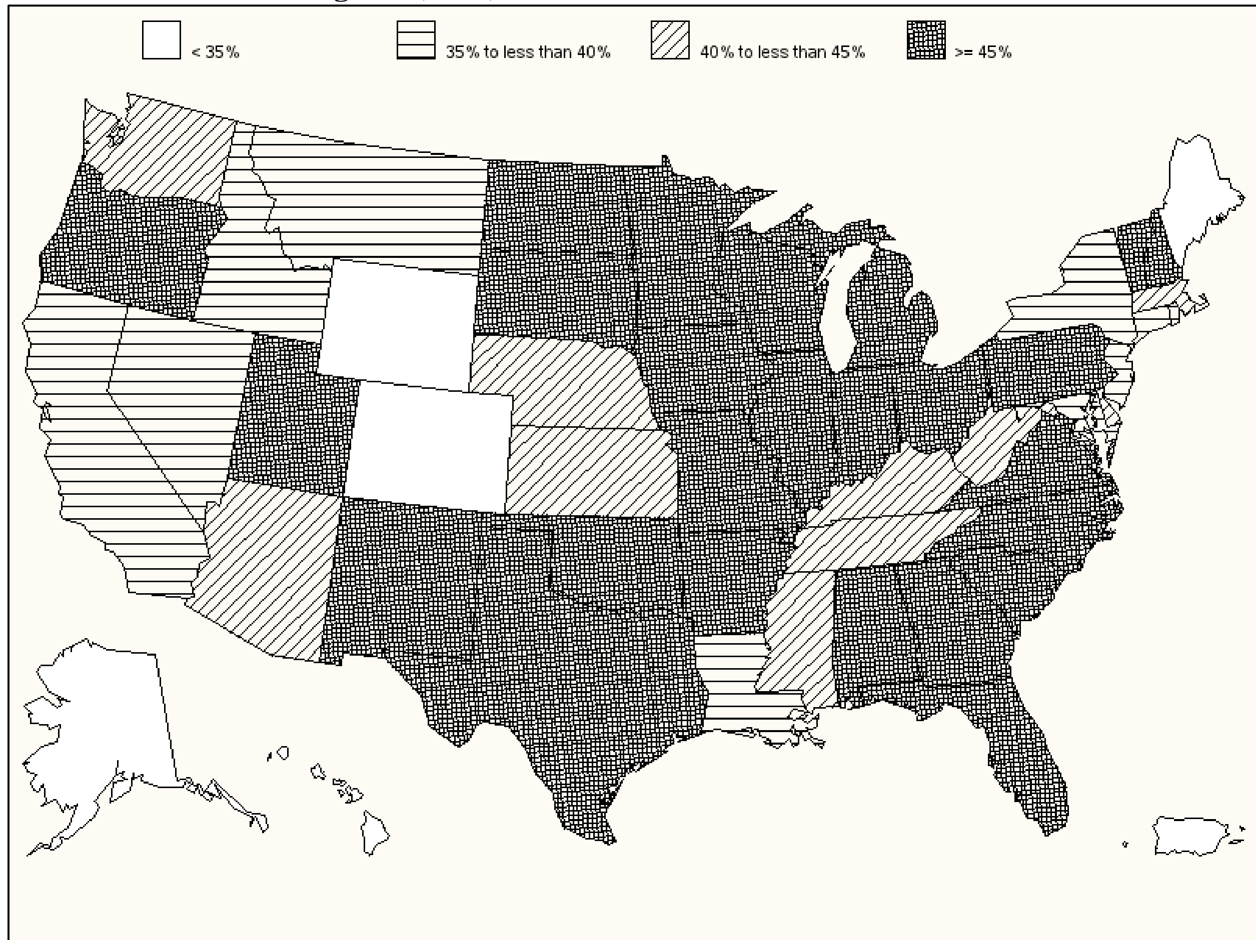
Notes for Table 29: Results include eligible professionals who were part of a practice that participated under the GPRO.

Among the 46,738 eligible professionals within practices participating in the 2012 eRx Incentive Program under the GPRO, the five most common eligible professional specialties were family practice, internal medicine, nurse practitioner, cardiology, and physician assistants; these specialties represented 17 percent, 14 percent, eight percent, six percent, and five percent, respectively, of all eligible professionals within practices participating in the eRx Incentive Program under the GPRO (data not shown).

There was a strong relationship between the number of Medicare beneficiaries seen by an eligible professional and the likelihood of participating in the 2012 eRx Incentive Program (Appendix Table A41). Eligible professionals with more than 200 eligible beneficiaries with an eligible eRx instance had a participation rate of 73 percent, compared to nine percent among eligible professionals with fewer than 25 beneficiaries on whom to report data, and 33 percent among those with 26 to 100 patients on whom to report data.

Participation rates in the 2012 eRx Incentive Program varied by state. Figure 14 presents the distribution of participation rates across the country. Excluding territories, the participation rate in the 2012 eRx Incentive Program ranged from 24 percent in Alaska (424 eligible professionals) to approximately 65 percent in North Dakota (1,850 eligible professionals). States with the highest participation rates were concentrated in the South and Midwest. The number of eligible professionals participating in the 2012 eRx Incentive Program ranged from below 1,000 in Wyoming, Alaska, and Hawaii to over 20,000 in California, New York, Texas, and Florida (Appendix Table A42). It should be noted that some state law limitations on electronic prescribing may affect eligible professionals' participation in the eRx Incentive program.

Figure 14: Geographic Distribution of Eligible Professionals Participating in the eRx Incentive Program (2012)



Note for Figure 14: Results included reporting via the claims, registry, and EHR mechanisms as well as data for eligible professionals who belong to a practice that participated under the GPRO. The data used to populate this map can be found in Appendix Table A42.

D. Incentive Eligibility

To qualify for the 2012 incentive payment equal to one percent of estimated Part B MPFS allowed charges for covered professional services furnished by the eligible professional during the reporting period, an eligible professional or a group practice participating in the eRx Incentive Program must have been a successful electronic prescriber (as described above) and their allowed charges for services identified in the eRx quality measure's denominator must have comprised at least ten percent of the eligible professional's or practice's total 2012 estimated Part B MPFS allowed charges (the 10% limitation threshold).

In 2012, over two-thirds (227,447) of eligible professionals (including eligible professionals within group practices that received an incentive under the GPRO) qualified for an incentive in the eRx Incentive Program (Table 5). All seven practices participating under the Small GPRO

qualified for incentives, totaling $561,703. Under the Large GPRO, 56 of the 59 participating practices earned incentives, totaling $21,472,790 (Appendix Table A45).

Table 30 presents the specialties with the highest number of eligible professionals qualifying for an eRx incentive in 2012. Family practice and internal medicine were among the specialties with the largest number of participants.

As seen in Appendix Table A41, incentive eligibility rates were highest among those participating via Small and Large GPROs (100 and 99 percent, respectively) compared with claims (60 percent). Incentive eligibility rates were also notably higher among individual participants in practices with at least 200 beneficiary visits (77 percent) compared to those with 26 to 100 beneficiary visits (36 percent).

Table 30: Specialties with the Highest Incentive Eligibility for the eRx Incentive Program (2012)

Specialty	Eligible Professionals who Participated	Eligible Professionals who were Incentive Eligible	Percent of Participating Eligible Professionals who were Incentive Eligible
Specialties with highest counts	--	--	--
Family Practice	54,596	41,571	76.1%
Internal Medicine	47,454	36,518	77.0%
Nurse Practitioner	27,057	15,098	55.8%
Cardiology	17,856	13,378	74.9%
Physician Assistant	18,107	10,280	56.8%

Notes for Table 30: Results include eligible professionals who were part of a practice that participated under the eRx GPRO.

Though 227,447 eligible professionals qualified for incentives in the 2012 eRx Incentive Program, 230,071 eligible professionals were successful electronic prescribers in 2012 (data not shown). Of those eligible professionals, 2,624 failed to meet the 10 percent limitation threshold for incentive eligibility (Appendix Table A43). Among eligible professionals with an MD/DO, the specialties with the highest rates of successful electronic prescribers who did not reach the 10 percent threshold (and with more than one eligible professional who failed to reach the threshold) included nephrology (six percent) and dermatology (three percent).

E. eRx Payment Adjustment

Beginning in 2012, section 1848(a)(5) of the Social Security Act requires CMS to apply a payment adjustment to eligible professionals who are not successful electronic prescribers under the eRx Incentive Program. For the 2013 eRx payment adjustment, eligible professionals who did not meet the requirements described below were subject to a 1.5 percent reduction in the MPFS for Medicare Part B services furnished between January 1 and December 31, 2013, and increase from the 1.0 percent reduction imposed by the 2012 eRx payment adjustment on services furnished in 2012.

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

- Those that were not physicians (MD/DO or podiatrist), nurse practitioners, or physician assistants as of April 9, 2012, based on primary taxonomy code in the National Plan and Provider Enumeration System (NPPES).
- Those that did not have at least 100 eligible claims containing an encounter code in the measure denominator.
- Those that did not meet the 10% limitation threshold were not eligible for the adjustment.

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

- They were (1) successful eRx prescribers during 2011 eRx Incentive Program year by reporting the G8533 code on at least 25 eligible instances between January 1, 2011 and December 31, 2011; or (2) were participating in 2012 and reported the G8533 code via claims for at least 10 Medicare billable services (for individual participants) during the six month period from January 1 through June 30, 2012.
    - For practices reporting via GPRO, the minimum reporting criteria to avoid the payment adjustment during the calendar year 2011 or first half of 2012 period were 2,500 instances for Large GPRO and 625 for Small GPRO.
- They reported G-code G8644 (defined as not having prescribing privileges) at least one time on an eligible claim between January 1 and June 30, 2012.
- They submitted and were granted a significant hardship exemption via claims by June 30, 2012:
    - G8642: The eligible professional practices in a rural area without sufficient high speed internet access.
    - G8643: The eligible professional practices in an area without sufficient available pharmacies for electronic prescribing.
- Or for group practices reporting under the GPRO, they indicated a hardship or lack of prescribing privileges to CMS during self-nomination.
- They submitted and were granted a "Hardship Exemption Request" by June 30, 2012 through the Communication Support Page for the following reasons:
    - Eligible professionals (or group practices reporting under the GPRO with eligible professionals) registered to participate in the Medicare or Medicaid EHR Incentive Programs and adopt Certified EHR Technology or who achieved meaningful use during January 1, 2011 and June 30, 2012 and attested to this by January 31, 2013.
    - Inability to electronically prescribe due to local, state, or federal law or regulation (e.g., controlled substances).

- Limited prescribing activity.
- Insufficient opportunities to report the electronic prescribing measure due to limitations of the measure's denominator.

In total, 59,955 eligible professionals (including those under the GPRO) were subject to the 2013 payment adjustment (Appendix Table A44). Table 31 presents the specialties with the highest number of eligible professionals subject to the 2013 eRx payment adjustment. Appendix Table A44 lists the number of eligible professionals subject to the payment adjustment for all specialties. Family practice and internal medicine had the largest number of eligible professionals (9,218 and 7,980, respectively) subject to the adjustment.

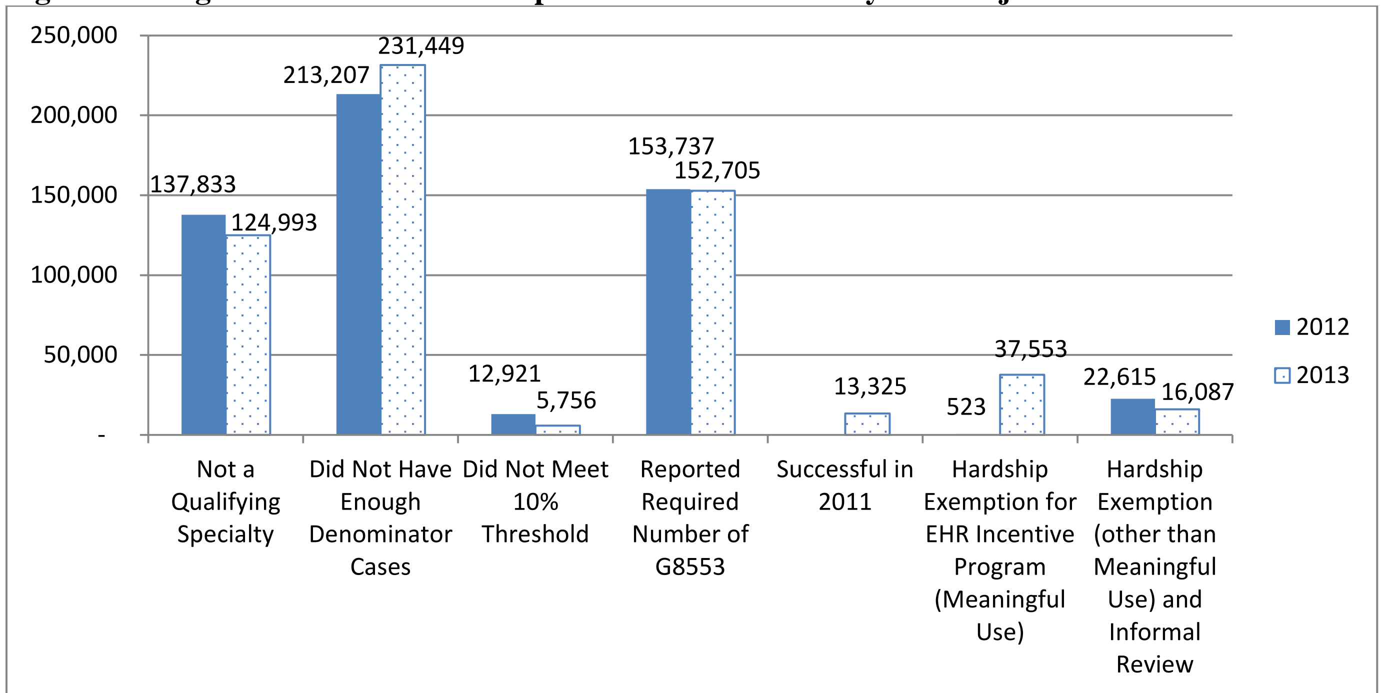
Table 31: Specialties with the Largest Number of Eligible Professionals Subject to the 2013 eRx Payment Adjustment

Specialty	Eligible Professionals Subject to the Payment Adjustment	Percent of Eligible Professionals Subject to the Payment Adjustment
Family Practice	9,218	15.4%
Internal Medicine	7,980	13.3%
Nurse Practitioner	5,818	9.7%
Psychiatry	5,559	9.3%
Physician Assistant	3,181	5.3%
Podiatrist	2,666	4.4%
Orthopaedic Surgery	2,428	4.0%
Ophthalmology	1,879	3.1%
Cardiology	1,833	3.1%
Dermatology	1,627	2.7%

Notes for Table 31: Results include eligible professionals who were part of a practice that participated under the eRx GPRO.

As seen in Figure 15, the three most common reasons for avoiding the 2013 eRx payment adjustment were: (1) not having enough denominator cases (N=231,449), (2) reporting the required number of G8553 (N=152,705); and (3) not being a physician, nurse practitioner, or physician assistant (124,933). Another 37,553 were granted a hardship exemption due to EHR Incentive Program participation and 16,087 were granted a hardship exemption for other reasons, either through a hardship request on the Communication Support Page or through an informal CMS review.

Figure 15: Eligible Professionals Exempt from the 2013 eRx Payment Adjustment



Notes for Figure 15: Counts for the five pairs of columns on the left are unduplicated and reflect the application of a hierarchy of automatic exemption reasons in the order shown. Counts for the exemptions due to hardship requests are also unduplicated within each column, and do not include any eligible professionals who were automatically exempt (i.e. there is not any overlap with any other columns in the figure).

Among the practices reporting under the GPRO that were not subject to the 2013 payment adjustment, the majority reported the required number of QDCs (55), six practices were successful e-prescribers in 2011, and seven practices were granted an exemption after reporting a hardship (data not shown).

V. FEEDBACK REPORTS

A. Background

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

- Individual eligible professionals who participate individually in the Physician Quality Reporting System or the eRx Incentive Program can obtain an NPI-level feedback report.
- If a practice did not participate under the GPRO in the Physician Quality Reporting System or the eRx Incentive Program and there was at least one eligible professional who participated in either program, then the practice can obtain TIN-level reports which also include NPI-level data for NPIs within the TIN.
- Group practices that participate under the eRx GPRO are only able to receive TIN-level eRx feedback reports.
- Group practices participating in the Physician Quality Reporting System GPRO or eligible professionals participating in a Medicare ACO under the Medicare Shared Savings Program or Pioneer ACO model receive information within their Quality and Resource Use Reports (QRUR).

B. Accessing Feedback Reports

Feedback reports can be accessed through two different processes. TIN-level feedback reports are available from the Physician and Other Health Care Professionals Quality Reporting Portal (Portal). A new process for requesting NPI-level feedback reports was established in 2011, allowing report requests to be made through the Physician Quality Reporting System and eRx Incentive Program Communication Support Page (CSP).[35] Feedback reports for multiple program years are available via both of these processes.

TIN-Level Feedback Report Access

2012 TIN-level (Physician Quality Reporting System GPRO/ACO) feedback report data is available within the QRUR (Quality Resource and Utilization Report) at the Physician Value Portlet. TIN-level feedback reports are not available from the PQRS Portal for the PQRS GPRO

[35] http://www.qualitynet.org/portal/server.pt/community/communications_support_system/234

or eligible professionals participating in Medicare ACOs for purposes of PQRS reporting through the Shared Savings Program or the Pioneer ACO model for 2012.

2012 TIN-level feedback reports for individual participants are available through the Portal. To access these reports, the TIN representative must create an Individuals Authorized Access to the CMS Computer Services (IACS) account, which is required in order for the TIN representative to log on to the Portal. The Portal, accessible via QualityNet, is the secured entry point to access the reports. Each feedback report is safely stored online and is accessible only to persons specifically authorized by that TIN. For further information regarding this process, see the Physician Quality Reporting System website on the Educational Resources page.[36]

NPI-Level Feedback Report Access

In 2011 the CSP was made available so that individual eligible professionals can request 2008-2012 NPI-level feedback reports. The CSP is available through the Portal, and does not require an IACS account. For further information regarding this process, see the Education Resources page of the Physician Quality Reporting system website.

C. Report Content

The 2012 Physician Quality Reporting System feedback reports for individual participants were packaged at the TIN-level, with individual-level reporting (or NPI-level) and performance information for each eligible professional who reported under that TIN for services furnished during the reporting period. Reports included information on reporting rates, QDC errors, clinical performance, and incentives earned by eligible professionals, with summary information on reporting success and incentives earned at the practice (TIN) level. Reports also included information on the MAV process and any impact it had on the eligible professional's incentive eligibility. Physician Quality Reporting System and eRx Incentive Program participants do not receive claim-level details in the feedback reports.

For both the Physician Quality Reporting System and eRx Incentive Programs, all Medicare Part B claims submitted and all registry, EHR and GPRO data received for services from January 1, 2012 – December 31, 2012 (for the 12-month reporting period) and for services from July 1, 2012 – December 31, 2012 (for the 6-month reporting period) were analyzed to determine whether the eligible professional or group qualified for an incentive according to the specific reporting criteria for the respective reporting mechanism.

An annual eRx payment adjustment Interim Feedback Report is made available to those eligible professionals and group practices reporting under the GPRO who submitted at least one eligible instance and were an MD/DO, Podiatrist, Nurse Practitioner, or Physician Assistant. This reporting includes ten months of Medicare Part B MPFS claims data (from January 1, 2012 – October 31, 2012) to inform the eligible professionals and group practices reporting under the GPRO of their status in meeting the eRx Incentive Program requirements for being a successful electronic prescriber during the reporting period.

[36] For more detail, see http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html

VI. HELP DESK

A. Background

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

B. Support Desks

3. Previously, the External User Services (EUS) Help Desk provided assistance with obtaining an IACS Security Login for access to the Physician Quality Reporting System Portal. Near the end of 2010, the IACS support for the Physician Quality Reporting System was merged with the QualityNet Help Desk to address vetting for the Security Official role in Organizations, IACS account issues, the new Annual Recertification requirement, assistance in obtaining the data submission role, etc. Eligible professionals still need to contact the EUS Help Desk for issues related to Medicare Enrollment and the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).

4. The CMS A/B MAC and Carrier Provider Contact Centers provide Medicare enrollment and claims submission support. This now includes the responsibility of disbursing the Physician Quality Reporting System and eRx payments to eligible professionals who earned incentives, paid at the TIN level. They answer questions related to payment disbursement, Remittance Advice, and any offsets or adjustments. The A/B MAC Carriers previously were tasked with accepting request for individual NPI-level feedback reports through the Alternative Feedback Report Request Process. Instead, the CSP was made available in early 2012 as a means for individual eligible professionals to request 2008-2012 NPI-level feedback reports. The CSP is available through the Portal, and does not require an IACS login. This alternative was implemented in response to some difficulties eligible professionals were having obtaining their IACS login.

5. The QualityNet Help Desk initially consisted of one level of support, known as Tier I, which consisted of a team dedicated to issues related to the Physician Quality Reporting System and eRx Incentive Programs. This tier handled questions in the summer and fall of 2008 regarding 2007 program year payments and feedback reports, as well as questions regarding 2008 program year reporting. They were available to answer a range of questions on issues such as eligibility, measures, reporting options, portal login, feedback reports, registries, and payments. In the summer of 2009, a second tier was added, known as Inquiry Support, to address specific measure questions and assist CMS with escalated payment or report issues. This tier was able to provide a level of detailed data review to eligible professionals who did not qualify for an incentive and needed information in addition to their feedback report. The Inquiry Support team became the Tier II Inquiry Support level to handle claims detail requests as well as other data specific

issues. In 2010, a Tier II Inquiry Support team was implemented to focus on providing answers to measures questions and program inquiries for both individual measure reporting as well as measures groups reporting, so that eligible professionals could better understand their feedback reports and use that knowledge to be more successful in future years. Near the end of 2010, the IACS support for the Physician Quality Reporting System transitioned to the QualityNet Help Desk (Tier I). This includes vetting for the Security Official role in Organizations, IACS account issues, the new Annual Recertification requirement, assistance in obtaining the data submission role, etc. Eligible professionals still need to contact the EUS Help Desk for issues related to Medicare enrollment and the PECOS system. In 2011, the QualityNet Help Desk at all levels also began to assist with questions related to the eRx payment adjustments for 2012-2014.

6. There are additional Support Teams that the QualityNet Help Desk Tiers work with to resolve related issues:

    a. The EHR Meaningful Use Information Center assists with Medicare EHR Incentive Program reporting, as well as with issues stemming from the eRx payment adjustment EHR-related significant hardship exemptions.

    b. The Tier II Vetting teams assist with vetting new EHR, Registry, and MOCP Vendors, help train these entities, and assist with file submissions at the end of the reporting periods.

    c. The Tier II ACO Help Desk provides guidance related to ACOs that report (via the GPRO Web Interface) on behalf of eligible professionals for purposes of Physician Quality Reporting System reporting under the Medicare Shared Savings Program or the Pioneer ACO model.

    d. The Physician Value Tier II Help Desk assists with Value-Modifier (VM) and QRUR questions, as well as online registration to avoid Physician Quality Reporting System or VM adjustments.

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

1. External User Services Help Desk for Medicare enrollment and PECOS questions:

    - Phone: 1-866-484-8049
    - TTY/TDD: 1-866-523-4759 (Monday-Friday; 7am-7pm EST)
    - Email: EUSSupport@cgi.com

2. CMS A/B MAC and Carrier Provider Contact Centers:

    - To get information regarding Contact Centers, see the “Provider Compliance Group Interactive Map” by clicking on the following link: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html.

3. QualityNet Help Desk for first-level questions on IACS, Portal Login, payments, reports, measures, GPRO, ACO, Physician Value, eRx adjustments, file submissions etc. Issues may then be escalated to the appropriate Tier II or Tier III support teams:

    - Phone: 1-866-288-8912
    - TTY: 1-877-715-6222
    - Email: Qnetsupport@sdps.org

VII. CONCLUSION

The Physician Quality Reporting System and the eRx Incentive Program reporting requirements have expanded since their inception to encourage participation and to increase reporting success by eligible providers. These requirements have also helped prepare eligible professionals for future payment adjustments associated with these important programs, and to signal Medicare's move toward the use of a value-based payment modifier as authorized under section 3007 of the Affordable Care Act.[37]

After the first year of the eRx payment adjustment, growth in the eRx Incentive Program slowed from 2011 to 2012; however, more than four out of ten eligible professionals participated, use of the EHR mechanism to submit eRx data increased substantially, and over 13 million beneficiaries received an electronic prescription through the 2012 eRx Incentive Program. In addition, the number of eligible professionals who were subject to the 2013 eRx payment adjustment fell by over one half from the 2012 adjustment.

While recent growth in individual reporters in the Physician Quality Reporting System was modest, there was an increase in the number of eligible professionals in practices participating via group options, particularly those in the ACO program, as well as a very large increase in the number of eligible professionals reporting via a qualified EHR (most via the new Data Submission Vendor option). The 2013 programs will introduce new options for group reporting: a new GPRO option for group practices with 2 to 24 eligible professionals, a registry reporting option for groups, and a reduction in the number of measures required by group reporters under the Physician Quality Reporting System.

The applicable quality percentage for the 2013 eRx Incentive Program will fall from one to one-half percent while the 2014 eRx payment adjustment applicable percent will increase from one to 1.5 percent. These features may encourage continued increases in electronic prescribing as the eRx Incentive Program sunsets. In addition, physicians in groups with 100 or more eligible professionals who participate in the 2013 Physician Quality Reporting System (i.e. report at least one measure) can avoid the 2015 value-based modifier adjustment of one percent; these physicians will be able to participate via the web interface, registries, or a new administrative claims reporting mechanism available to eligible professionals. Based on past experience with the 2011 eRx Incentive Program when the 2012 payment adjustment was implemented, this may lead to a jump in the program participation rate.

Preliminary data suggest a continued increase in participation in the Physician Quality Reporting System in the 2013 program year. For example, the number of individuals participating via the claims-based mechanism was already larger based on six months of data in 2013 than in 2012. Preliminary data for 2013 eRx Incentive Program show the number of eligible professionals who participated by reporting through claims during the first six months of 2013 is approximately three quarters of all eRx Incentive Program participants using any reporting mechanism during 2012. Moreover, the increase in the number of successful reporters in 2012 suggests further

[37] See following link for more details: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

decreases in the number subject to the 2014 payment adjustment compared to the 2013 adjustment.

CMS is taking several steps to foster continued growth and participation in the Physician Quality Reporting System. First, CMS is actively working to reduce burden on eligible professionals by allowing them to report once. This is accomplished by aligning measures reported through various quality reporting initiatives. For example, in 2012 the Medicare EHR Incentive Pilot was established, whereby eligible professionals could report data on the same set of electronic clinical quality measures (eCQMs) and fulfill the requirements for satisfactory reporting under the Physician Quality Reporting System while also meeting the eCQM component of Meaningful Use under the Medicare EHR Incentive Program. Additionally, CMS has aligned the measure sets for eligible professionals participating in the Medicare Shared Savings Program and the Pioneer ACO Model with the GPRO web interface option under the Physician Quality Reporting System. Second, CMS is streamlining the measures available by eliminating measures that are topped out, redundant, or under-reported. Lastly, CMS continues to align with the National Quality Strategy by streamlining measures across programs as it balances competing goals of establishing parsimonious sets of measures while including sufficient measures to facilitate provider participation.

ABBREVIATIONS

Table 32: Abbreviations

Abbreviation	Meaning
ACO	Accountable Care Organization
AMA	American Medical Association
CAP	Community-Acquired Pneumonia
CKD	Chronic Kidney Disease
CMS	Centers for Medicare & Medicaid Services
COPD	Chronic Obstructive Pulmonary Disease
CPT	Current Procedural Terminology
CSP	Communication Support Page
CVP	Cardiovascular Prevention
eCQM	Electronic Clinical Quality Measure
EHR	Electronic Health Record
eRx	Electronic Prescribing Program
EP	Eligible Professional
EUS	External User Services
FFS	Fee for Service
GPRO	Group Practice Reporting Option
HIC	Health Insurance Claim number
HCPCS	Healthcare Common Procedure Coding System
HCV	Hepatitis C Virus
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
IACS	Individuals Authorized Access to CMS Computer Services
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
IVD	Ischemic Vascular Disease
MAV	Measure Applicability Validation
MG	Measures Groups
MD/DO	Doctor of Medicine or Doctor of Osteopathy
MIEA	Medicare Improvements and Extension Act of 2006
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007
MPFS	Medicare Physician Fee Schedule
NCQA	National Committee for Quality Assurance
NPPES	National Plan and Provider Enumeration System
NPI	National Provider Identifier
PCPI	Physician Consortium for Performance Improvement
PQRI	Physician Quality Reporting Initiative
PQRS	Physician Quality Reporting System

Abbreviation	Meaning
PECOS	Provider Enrollment, Chain, and Ownership System
QDC	Quality Data Code
QRUR	Quality Resource Use Report
SCHIP	State Children's Health Insurance Program
TRHCA	Tax Relief and Health Care Act of 2006
TIN	Taxpayer Identification Number
VBP	Value-Based Purchasing
VM	Value Modifier