2010 Reporting Experience

Including Trends (2007 – 2011)

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

2/22/2012

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Abbreviations

AQA (Ambulatory Care Quality Alliance or AQA Alliance)
AMA (American Medical Association)
CAP (Community-Acquired Pneumonia)
CKD (Chronic Kidney Disease)
CMS (Centers for Medicare & Medicaid Services)
CABG (Coronary Artery Bypass Graft)
CPT (Current Procedural Terminology)
EHR (Electronic Health Record)
eRx (Electronic Prescribing Program)
EP (Eligible Professional)
ESRD (End Stage Renal Disease)
EUS (External User Services)
FFS (Fee For Service)
GPRO (Group Practice Reporting Option)
HIC (Health Insurance Claim number)
HCPCS (Healthcare Common Procedure Coding System)
HIV/AIDS (Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome)
IM (Individual Measures)
IACS (Individuals Authorized Access to CMS Computer Services)
ICD-9-CM (International Classification of Diseases, 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)
MMA (Medicare Modernization Act of 2003)
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)
NQF (National Quality Forum)
ORDI (Office of Research, Development, and Information)
PCPI (Physician Consortium for Performance Improvement)
PFS (Physician Fee Schedule)
PQRI (Physician Quality Reporting Initiative)
PQRS (Physician Quality Reporting System)
PECOS (Provider Enrollment, Chain, and Ownership System)
PVRP (Physician Voluntary Reporting Program)
QDC (Quality Data Code)
TRHCA (Tax Relief and Health Care Act of 2006)
TIN (Taxpayer Identification Number)
VBP (Value-Based Purchasing)

I. EXECUTIVE SUMMARY

The Centers for Medicare & Medicaid Services (CMS) implemented two pay-for-reporting programs for eligible professionals.[1] The Physician Quality Reporting System (formerly, Physician Quality Reporting Initiative or PQRI), authorized under Section 101(b) of division B of the Tax Relief and Health Care Act (TRHCA) of 2006 (Public Law 109423; 120 Stat. 2975), entered its fourth year in 2010 and has grown substantially from its inception in 2007. The Electronic Prescribing (eRx) Incentive Program, authorized under Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), was introduced in 2009 as a separate incentive vehicle for eligible professionals. Prior to 2009, the eRx measure was an individual measure within the 2008 Physician Quality Reporting System. These programs reward eligible professionals—based on a percentage of the estimated Medicare Physician Fee Schedule (PFS) allowed Part B charges for covered professional services furnished by the eligible professional during the reporting period—for reporting data on standardized clinical quality measures. This report summarizes the reporting experience of eligible professionals in these programs in 2010, historical trends, and preliminary results for the 2011 program year. Unless otherwise noted, all tables and figures present 2010 data. Findings reported at the practice level include eligible professionals encompassed within practices that participated through the group practice reporting option (GPRO). While GPRO was not an individual participation option, this information was sometimes combined with the individual participation options to describe the number of individual eligible professionals encompassed within GPROs.

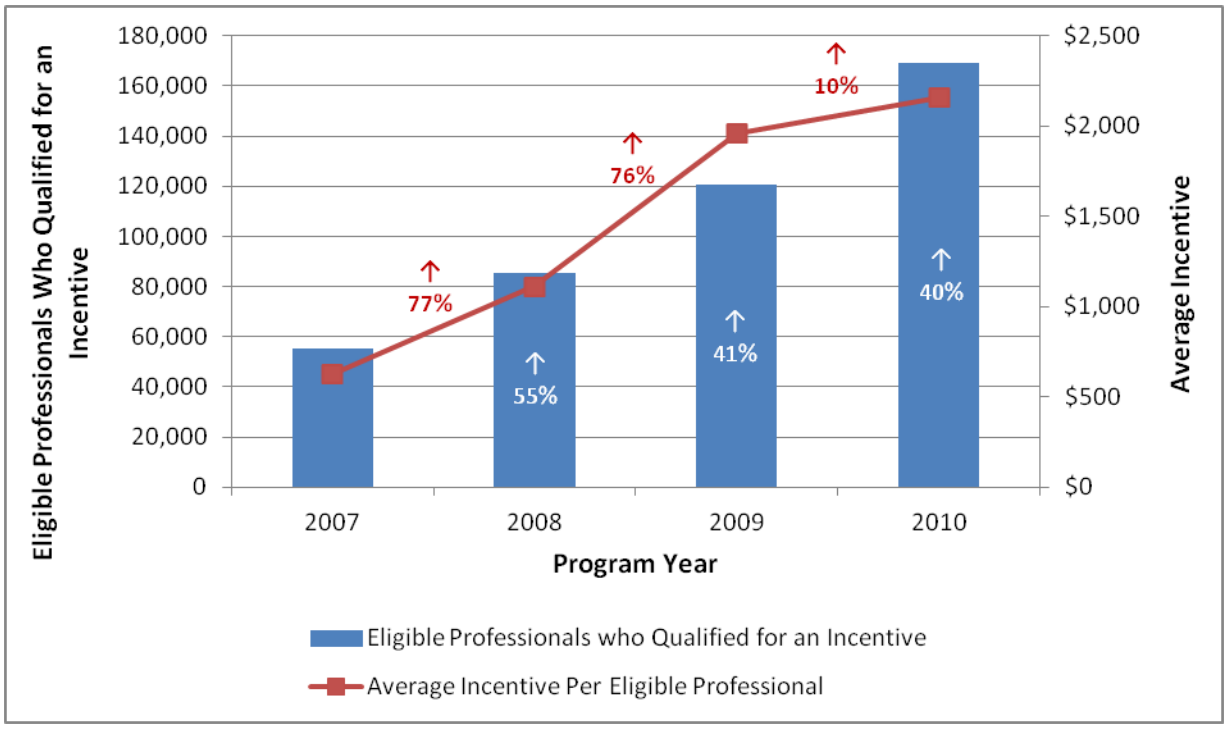
Incentive Payments

- The Physician Quality Reporting System and the eRx Incentive Program, combined, paid $662,531,035 in incentives in 2010 across all participation options, a 72% increase from 2009 ($384,704,248).
- A total of $391,635,495 in Physician Quality Reporting System incentives was paid by CMS for the 2010 program year, which encompassed 168,843 individual eligible professionals and 19,232 practices.[2]
    - Total incentive payments for the 2010 Physician Quality Reporting System increased 65% compared to 2009 ($236,696,432).
    - The number of practices that qualified for an incentive for the 2010 Physician Quality Reporting System (19,232) increased 50% compared to 2009 (12,781).
    - The average incentive was $2,157 per eligible professional and $20,364 per practice (compared with $1,962 and $18,519, respectively, in 2009).
    - Additionally, 24,823 eligible professionals were encompassed within 35 practices that qualified for an incentive through the Physician Quality Reporting System GPRO.

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

[2] The total incentive amount and practice counts included practices that participated in the GPRO; the count of individual eligible professionals did not.

Figure 1. Number of Eligible Professionals who Qualified for a Physician Quality Reporting System Incentive and Average Amounts Among Individual Participation Options (2007 to 2010).



Note for Figure 1: Results included all individual reporting options (i.e., claims, registry and EHR).

- A total of $270,895,540 in eRx Incentive Program incentives was paid for the 2010 program year, which encompassed 65,857 individual eligible professionals and 18,713 practices.
    - Total incentive payments for the 2010 eRx Incentive Program increased 83% compared to 2009 ($148,007,816).
    - The number of practices that qualified for an incentive in the 2010 eRx Incentive Program (18,713) increased 83% compared to 2009 (10,207).
    - The average eRx incentive payment was $3,836 per eligible professional and $14,476 per practice.
    - Additionally, 17,093 eligible professionals were encompassed within 23 practices that qualified for an incentive through the eRx GPRO.

Expansion of Programs and Eligibility

Table 1. Summary of Reporting Options for the Physician Quality Reporting System and eRx Incentive Program (2009 to 2011).

	Physician Quality Reporting System			eRx		
	2009	2010	2011	2009	2010	2011
Claims: Individual Measures	Yes	Yes	Yes	Yes	Yes	Yes
Claims: Measures Groups	Yes	Yes	Yes	N/A	N/A	N/A
Registry: Individual Measures	Yes	Yes	Yes	No	Yes	Yes
Registry: Measures Groups	Yes	Yes	Yes	N/A	N/A	N/A
Electronic Health Record (EHR)	No	Yes	Yes	No	Yes	Yes
Group Practice Reporting Option (GPRO)	No	Yes	Yes	No	Yes	Yes
Group Practice Reporting Option II (GPRO II)	No	No	Yes	No	No	Yes

- The 2010 program year introduced new GPRO and EHR options for reporting in both the Physician Quality Reporting System and the eRx Incentive Program to accompany the claims and registry submission options (Table 1).

Table 2. Number of Physician Quality Reporting System Measures (2009 to 2011).

	2009	2010	2011
Individual Measures	153	175	198
Measures Groups	7	13	14
EHR	N/A	10	20
GPRO	N/A	26	26
GPRO II	N/A	N/A	189

- The number of quality measures eligible professionals could choose from to report under the Physician Quality Reporting System continued to increase (Table 2).
- The measures reportable by the largest number of eligible professionals were mostly preventive measures, which are not specific to a given diagnosis or condition and apply to a broad range of specialties (Tables 3 and 11).

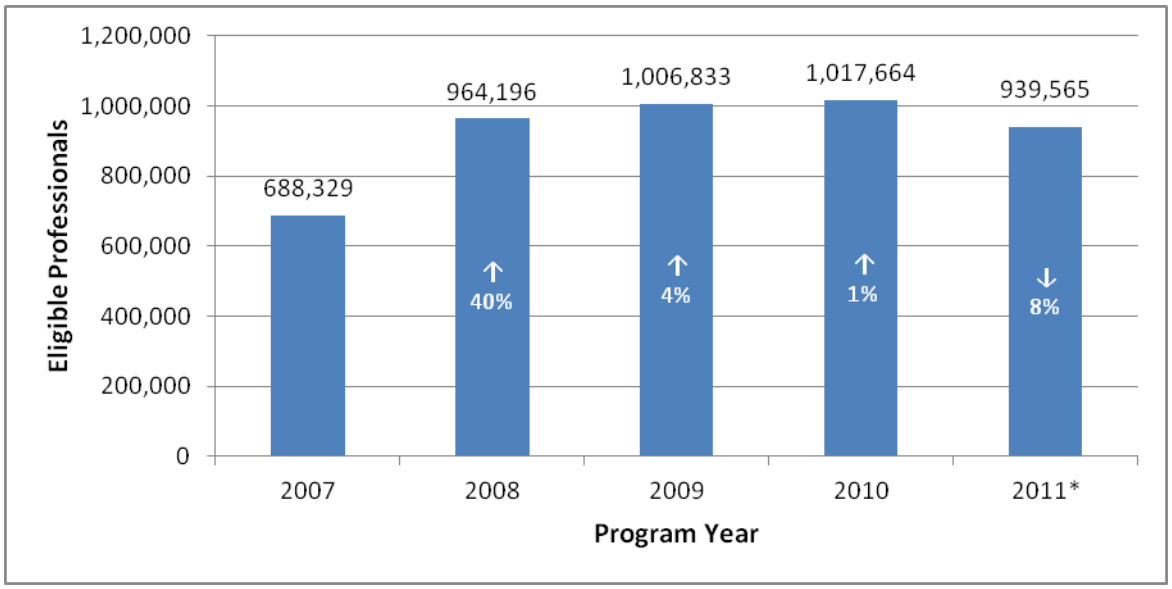
Table 3. Individual Measures Reportable by the Largest Number of Eligible Professionals for the Physician Quality Reporting System (2010).

Measure	Eligible Professionals
#124 HIT - Adoption/Use of EHRs	761,872
#128 Universal Weight Screening and Follow-Up	704,404
#130 Documentation of Current Medications	691,221
#173 Preventive Care and Screening: Unhealthy Alcohol Use – Screening	662,216
#114 Inquiry Regarding Tobacco Use	660,867

Note for Table 3: Results included the claims, registry and EHR options.

- More than 1 million eligible professionals could have participated in the 2010 Physician Quality Reporting System (Figure 2).
- Thirty-five practices were approved by CMS and therefore eligible to participate in the Physician Quality Reporting System through the GPRO.
- Eligible professionals who could participate in the Physician Quality Reporting System were concentrated in specialties such as family practice, internal medicine, and emergency medicine. CMS aims to include quality measures that are applicable to all specialties and has requested suggestions for measures to be included in the Physician Quality Reporting System.
- 696,663 eligible professionals could have participated in the 2010 eRx Incentive Program; 27 group practices that self-nominated and indicated their intent to report eRx were able to participate in the GPRO for the eRx Incentive Program.

Figure 2. Number of Professionals who were Eligible to Participate in the Physician Quality Reporting System (2007 to 2011*).



*Note for Figure 2: Results included the claims, registry, and EHR options. *Results for 2011 are preliminary only.*

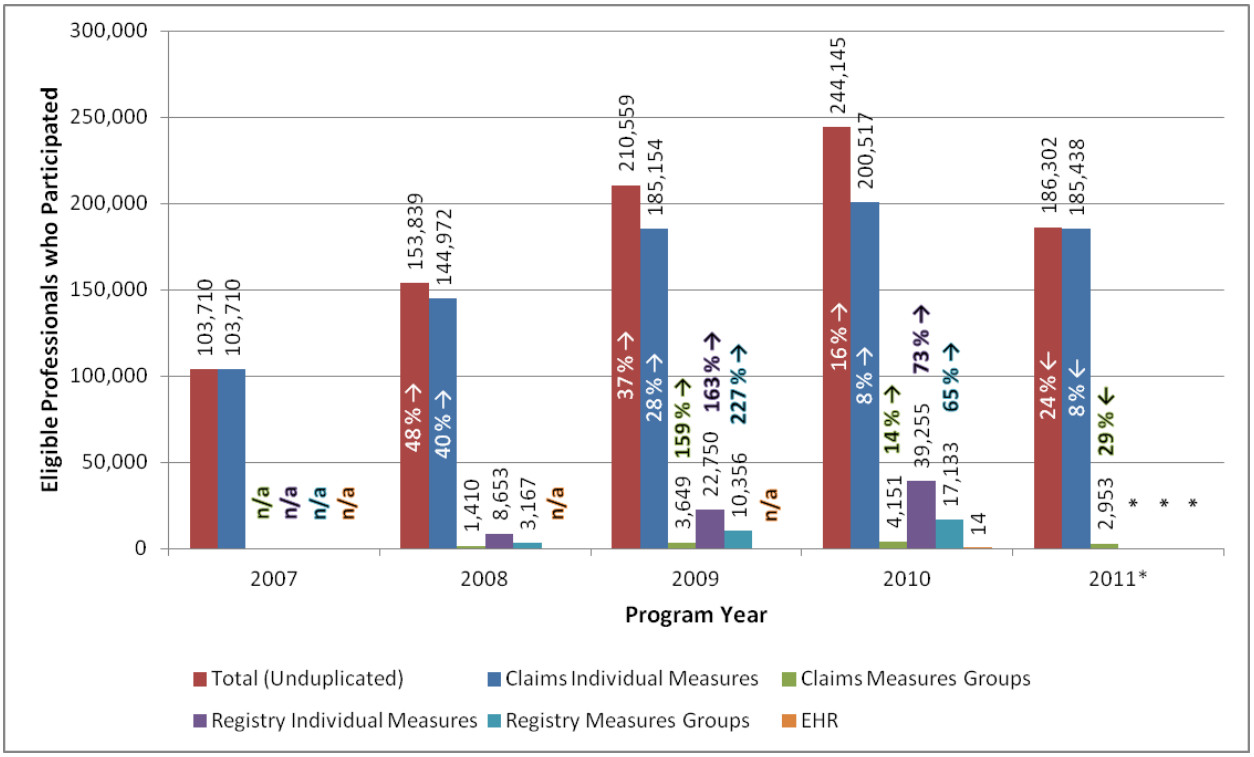
Participation

- Participation increased every year in both the Physician Quality Reporting System and eRx Incentive Program (Figures 3 and 4).
- Most recently (i.e., 2009 to 2010), the number of eligible professionals who participated individually increased 16% and 26% for the Physician Quality Reporting System, and eRx Incentive Program, respectively.
- In addition, preliminary counts for the 2011 eRx Incentive Program increased 42% among eligible professionals who participated individually (Figure 4).

- In 2010, 244,145 individual eligible professionals participated in the Physician Quality Reporting System through at least one reporting option, which is a notable increase from the roughly 100,000 who participated in 2007.[3]

- The participation rate among eligible professionals using any reporting option to participate in the Physician Quality Reporting System increased from 15% to 24% between 2007 and 2010. While the most common reporting option in the Physician Quality Reporting System continued to be individual measures reporting through claims, reporting via every option (i.e., claims, registry, individual measures, and measures groups) increased every year (Figure 3).

Figure 3. Number of Eligible Professionals who Participated in the Physician Quality Reporting System (2007 to 2011*).



*Note for Figure 3: Some eligible professionals participated in more than one option. *Results for 2011 are preliminary only; data for registry and EHR options are not yet available.*

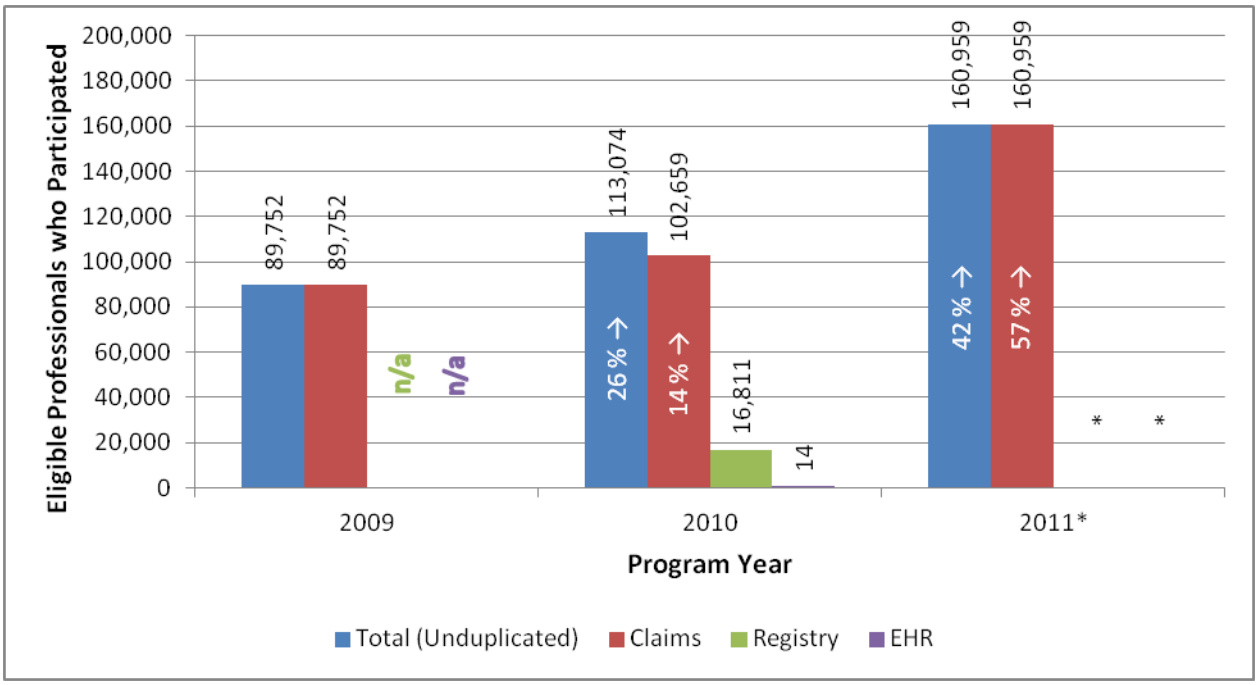
- In 2010, 14 eligible professionals participated by reporting via a qualified EHR system, the first year that this reporting mechanism was available under both the Physician Quality Reporting System and the eRx Incentive Program; this demonstrated the ability of these programs to collect information via EHRs.

- Introduction of the GPRO afforded additional opportunity for participation in the Physician Quality Reporting System and the eRx Incentive Program.

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

- All 35 practices—representing 24,823 eligible professionals—that self-nominated for the Physician Quality Reporting System GPRO reported measures through this option.
- In addition, 25 of these group practices participated in the eRx Incentive Program GPRO, which encompassed 17,879 eligible professionals.

Figure 4. Number of Eligible Professionals who Participated Individually in the eRx Incentive Program (2009 to 2011*).



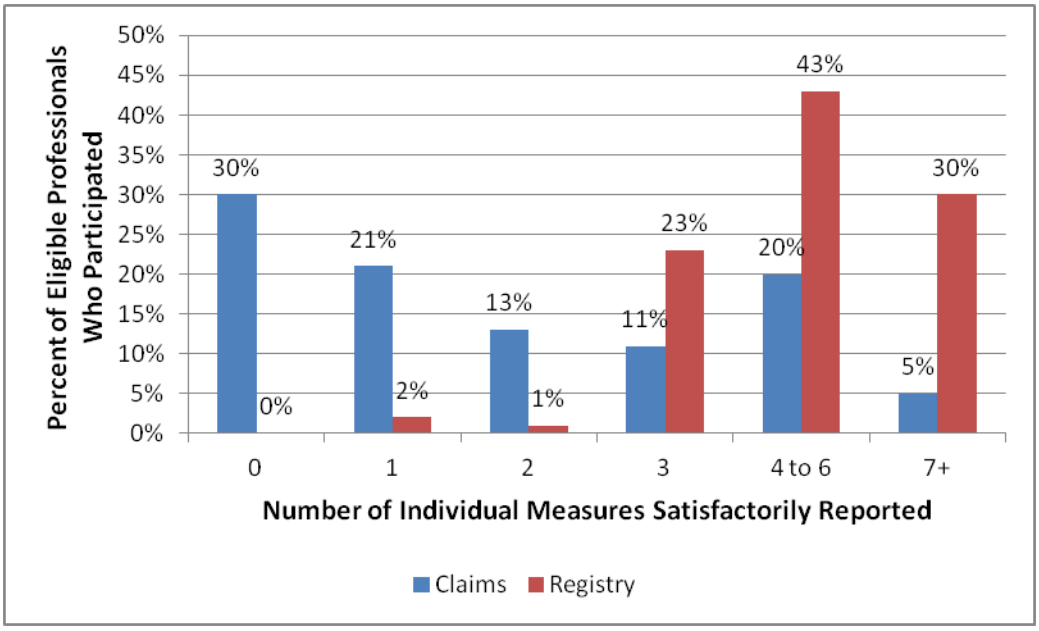
*Note for Figure 4: *Results for 2011 are preliminary only; data for registry and EHR options are not yet available.*

- In 2010, 113,074 eligible professionals participated individually in the eRx Incentive Program with nearly 9 out of 10 reporting through claims (Figure 4).
- In 2010, 16% of eligible professionals participated in the eRx Incentive Program, an increase from 13% in 2009.
- Some specialties participated in greater numbers in the 2010 programs than others.
  - Emergency physicians, family practitioners, internists and anesthesiologists had the largest numbers of participants in the Physician Quality Reporting System across all individual options. Internists and family practitioners were the most numerous participants in claims-based measures groups and registry submission options under the Physician Quality Reporting System.
  - Internists and family practitioners were the most numerous participants in the eRx Incentive Program while cardiologists and ophthalmologists had the highest participation rates (35% and 34%, respectively).

- Some eligible professionals and practices participated in both the Physician Quality Reporting System and the eRx Incentive Program (Table 4).
    - Over 64,000 individual eligible professionals and almost 13,000 practices participated in both programs.

Satisfactory Reporting and Challenges to Reporting

Figure 5. Distribution of Satisfactorily Reported Individual Measures for the Physician Quality Reporting System (2010).



Note for Figure 5: Satisfactory reporting required reporting on at least 80% of eligible instances.

- In 2010, 70% of eligible professionals who participated in the Physician Quality Reporting System satisfactorily reported at least one individual measure through claims, compared with 100% of registry participants (Figure 5).
    - The most common submission error was reporting a measure-specific QDC on a claim that did not also have the required procedure code.
- Nearly 6 of every 10 participants (59%) in the 2010 eRx Incentive Program successfully submitted at least 25 eligible instances.

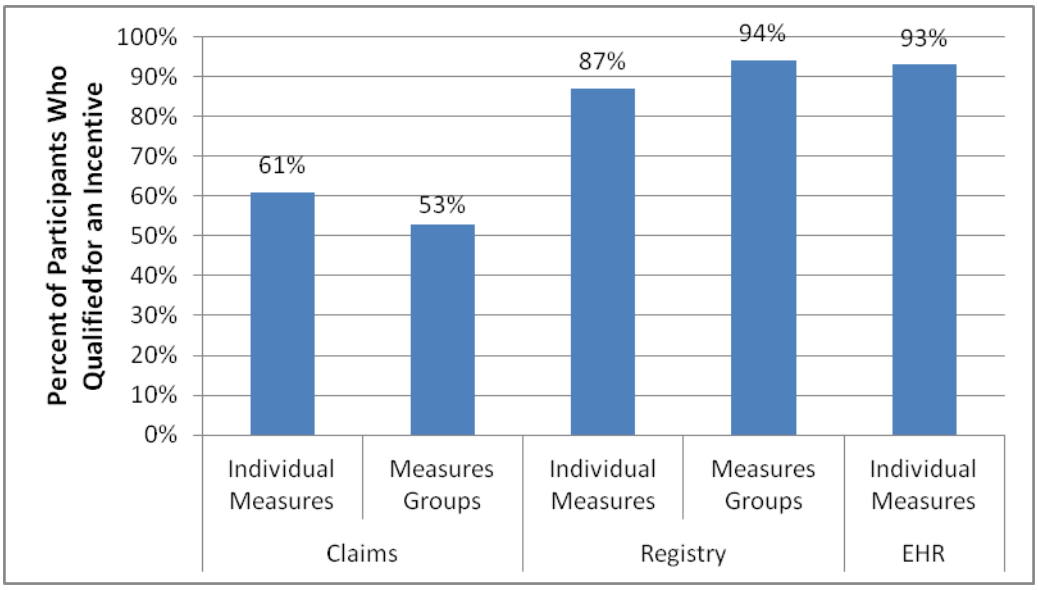
Incentive Eligibility

- Across all reporting options, nearly 7 in 10 participants (69%) in the 2010 Physician Quality Reporting System met the criteria for incentive eligibility.[4] Moreover, incentive eligibility rates increased every year since the program began in 2007, when the rate was only 53%.

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

- Over 6 out of 10 (62%) eligible professionals who participated through any claims reporting options in the 2010 Physician Quality Reporting System earned an incentive. The percent of participants who qualified for an incentive was 90% across all registry reporting options (Figure 6). Among the 14 eligible professionals participating via the EHR reporting option, 13 (93%) met the criteria for incentive eligibility.

Figure 6. Incentive Eligibility Rate by the Physician Quality Reporting System Reporting Option (2010).



Notes for Figure 6: An eligible professional could be incentive eligible under more than one option; but, could receive only one incentive payment. 14 eligible professionals participated through the EHR option.

- Almost 6 out of 10 (58%) eligible professionals who participated in the 2010 eRx Incentive Program qualified for an incentive.[5] The incentive eligibility rate increased modestly from roughly 54% in 2009.

- More than half of eligible professionals and practices that participated in both the Physician Quality Reporting System and the eRx Incentive Program qualified for an incentive through both programs and average incentives were notably larger.

[5] Valid reporting of the quality data code (G8553) is required for claims-based participation in the eRx Incentive Program.

Table 4. Eligible Professionals and Practices that Participated in both the Physician Quality Reporting System and eRx Incentive Program (2009 to 2011*).

	Eligible Professionals			Practices		
	2009	2010[a]	2011*	2009	2010	2011*
Participated	--	--	--	--	--	--
Either Program	254,890	322,956	297,555	36,998	45,313	48,139
Eligible for Both	153,586	202,358	194,468	31,454	39,391	42,875
Participated in Both	45,421	65,334	49,706	8,023	12,780	9,406
Percent [b]	29.6%	32.3%	25.6%	25.5%	32.4%	21.9%
Incentive Eligible	--	--	--	--	--	--
Both Programs	19,047	33,701	*	3,259	6,850	*
Percent [c]	41.9%	51.6%	--	40.6%	53.6%	--
Total Payments [d]	$132,244,918	$261,911,397	*	$184,400,352	$378,382,434	*
Average Payments [d]	$6,943	$7,902	*	$56,581	$55,238	*

Note for Table 4: [a] For 2010 only, eligible professional counts include 24,823 who were encompassed within a Physician Quality Reporting System GPRO and 17,879 within an eRx Incentive Program GPRO; 12,190 were encompassed within both GPROs. [b] This percent is the count that participated in both the Physician Quality Reporting System and eRx Incentive Program (i.e., participated in both programs) divided by the count that participated in at least one of these programs and could have participated in both (i.e., eligible for both [and participated in either]). [c] This percent is the count that qualified for an incentive through both programs divided by the count that participated in both programs. [d] These amounts are among those who qualified for an incentive through individual participation options in both programs. Results for 2011 are preliminary only; incentive information was not yet available.*

Table 5. Eligible Professionals' and Practices' Reporting Experience for the Physician Quality Reporting System and eRx Incentive Program (2010).

	Physician Quality Reporting System		eRx Incentive Program	
	Eligible Professionals	Practices	Eligible Professionals	Practices
Eligible	1,017,664	304,100	696,663	232,260
Participated	268,968	30,688	130,953	27,405
Claims	201,567	25,294	102,659	26,655
Registry	56,214	7,296	16,811	1,710
EHR	14	5	14	5
GPRO	24,823	35	17,879	25
Incentive Eligible	193,666	19,232	82,950	18,713
Total Payments	$364,254,804	$391,635,495	$252,636,669	$270,895,540
Average Payment	$2,157	$20,364	$3,836	$14,476

Note for Table 5: Some eligible professionals participated in more than one individual option. Eligible professional counts include 24,823 who were encompassed within a Physician Quality Reporting System GPRO (all were incentive eligible) and 17,879 within an eRx Incentive Program GPRO (17,093 were incentive eligible). The Total and Average Payments under the Eligible Professionals column reflect individual participants (i.e., do not include GPRO NPIs).

Summary

In summary, participation in the Physician Quality Reporting System and the eRx Incentive Program continued to grow. CMS continued to fine-tune these programs through, for example, added participation options (i.e., GPRO and EHR) and changing some reporting requirements (e.g., under the eRx Incentive program, requiring that eligible professionals report the electronic prescribing quality measure in 25 instances, instead of 50% of the time). These changes have been paralleled by increases in participation and total incentive amounts. Moreover, the numbers who qualified for an incentive and the average incentive amounts generally increased for individual eligible professionals and practices each year.

While the Physician Quality Reporting System and the eRx Incentive Program were designed to promote reporting of quality information, ultimately this information can be used to improve the quality of care provided to Medicare beneficiaries. The 2010 Physician Quality Reporting System accumulated quality information on over 12 million Medicare beneficiaries. This information can aid the development and evaluation of solutions to lessen the epidemic of chronic diseases such as obesity, diabetes, and heart disease. Moreover, the 2010 eRx Incentive Program revealed that over 113,000 eligible professionals and 27,000 practices implemented and used qualified electronic prescribing systems. Each patient who received electronic prescriptions has the potential to reap the demonstrated benefits of electronic prescribing such as improving prescription accuracy and reducing preventable adverse drug interactions. Accordingly, as participation in the Physician Quality Reporting System and the eRx Incentive Program grows, the usefulness of the information will also grow.

II. INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) implemented two pay-for-reporting programs for eligible professionals. The Physician Quality Reporting System, authorized under Section 101(b) of division B of the Tax Relief and Health Care Act (TRHCA) of 2006 (Public Law 109-423; 120 Stat. 2975) entered its fourth year in 2010 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), began as a standalone program in 2009. Currently, these programs reward eligible professionals—based on a percentage of the professional's estimated Medicare Part B PFS allowed charges for services furnished during the applicable reporting period—for reporting information on standardized clinical quality measures.

This report summarizes the experience of eligible professionals who participated in these programs in 2010 and historical trends. Section III presents detailed findings for the Physician Quality Reporting System and Section IV presents similar information for the eRx Incentive Program. Sections V and VI describe information about feedback reports available for the Physician Quality Reporting System and the eRx Incentive Program and services available from the Help Desk. Section VII concludes and describes upcoming changes to the programs. The Appendix is a separate document for interested readers, which contains additional descriptions of data, options and results.

This report uses the term "eligible professional" to describe physicians and other health care professionals who could participate in the Physician Quality Reporting System and eRx Incentive Program. The health care professionals who are eligible to participate in the Physician Quality Reporting System and eRx Incentive Program are listed on the CMS website.[6] In general, this includes professionals who furnish PFS covered professional services to Medicare Part B (including Railroad Retirement and Medicare Secondary Payer) beneficiaries for whom selected Physician Quality Reporting System measure(s) or the eRx Incentive Program measure are applicable.

The unit of analysis for describing eligible professionals was a combination of a professional's National Provider Identifier (NPI) number and the Taxpayer Identification Number (TIN) under which they billed for services; this is commonly referred to as a "TIN/NPI" (please see the Appendix for more detail). Results for the GPRO were described at the practice (TIN) level, although we provided counts of eligible professionals and specialties associated with a practice. Finally, data were summarized at both the program—inclusive of all submission options—and individual submission option level. Unless otherwise noted, data were reported at the program-level.

[6] www.cms.gov/PQRS/Downloads/EligibleProfessionals.pdf

http://www.cms.gov/ERxIncentive/05_Eligible%20Professionals.asp#TopOfPage

III. PHYSICIAN QUALITY REPORTING SYSTEM

A. Background

Program Description

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

The authorizing legislation for the program was originally set forth in Section 101(b) of division B (Medicare Improvements and Extension Act of 2006 [MIEA]) of the Tax Relief and Health Care Act of 2006 (Public Law 109-423; 120 Stat. 2975), commonly known as TRHCA, which was enacted on December 20, 2006. CMS initially referred to the physician quality reporting system 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. Professionals who chose to participate in the 2007 Physician Quality Reporting System and satisfied the reporting criteria on a set of quality measures were eligible for an incentive, subject to a cap, of 1.5% of the estimated Medicare Part B allowed 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 developing 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, nonperformance, or a performance exclusion. The Appendix to this report provides a description of how eligible professionals submit quality measure data to CMS.

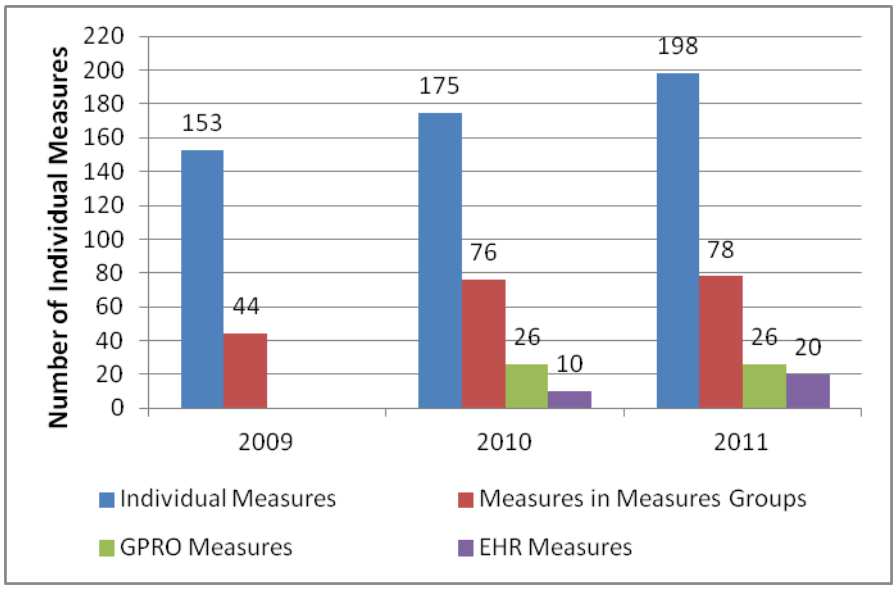
The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), enacted on December 29, 2007 (Pub. Law 110-173) extended the quality reporting system through 2008 and 2009. The MMSEA authorized incentive payments for 2008 and removed the cap on the total earned

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.

CMS expanded the available measures in the Physician Quality Reporting System each year aiming to maximize eligible professionals' ability to participate. The quality measures available for the 2008 program year increased to 119 measures, which included 117 clinical measures and 2 structural measures (i.e., use of electronic health records and electronic prescribing). These 119 measures passed the consensus-based review and approval process specified in the 2008 PFS Final Rule and were endorsed or adopted by a consensus organization such as the National Quality Forum (NQF) or the AQA Alliance (AQA). These 119 measures applied to all clinical disciplines and applied to procedures or visits that accounted for 95% of Medicare Part B spending in 2008. In the 2009 program year, CMS added 52 new quality measures and removed 18 measures, for a total of 153 measures. Eighteen of the 153 measures were only reportable through a registry and four measures were only reportable as a group due to concerns about the complexity of reporting select measures and measures groups.

CMS expanded the number of measures and reporting options for the 2010 Physician Quality Reporting System. Specifically, CMS added 30 new quality measures and removed 4 measures, for a total of 175 measures, an increase from 153 measures in 2009. One result of this expansion was the addition of more specialty measures; Appendix Table A1 lists the individual measures. Forty-six of the 153 measures were only reportable through a registry, which increased from 18 measures in 2009. As in 2009, four measures could only be reported as a measures group (i.e., not individually) in 2010. As demonstrated in Figure 7, the number of total available measures increased in the most recent program years.

Figure 7. Numbers of Measures in the Physician Quality Reporting System by Reporting Option (2009 to 2011).



Note for Figure 7: Categories are not mutually exclusive; for example, an individual measure may also be part of a measures group.

In addition to the growth of individual measures, measures groups were introduced in the 2008 program year and expanded each year thereafter. Measures Groups are a subset of four or more clinically-related measures. The 2009 program retained three of the four measures groups from 2008—diabetes mellitus (six measures), chronic kidney disease (five measures), and preventive care (nine measures)—and retired one group (ESRD). The following measures groups were added for 2009: rheumatoid arthritis (six measures), coronary artery bypass graft (CABG) surgery (ten measures), perioperative care (four measures), and back pain (four measures). While both the claims and registry reporting options had a measures group option, the CABG measures group could only be reported through a registry. The measures in the back pain measures group could only be reported as a group and not also as individual measures. Beginning in 2009, CMS introduced a new QDC that allowed eligible professionals reporting on measures groups to use a single code to indicate if all recommended quality actions were performed for each measure in the group. That is, eligible professionals could report a single QDC—referred to as a composite G-code—for the entire measures group. Before this code existed, eligible professionals reported one QDC for each measure within the measures group.

Beginning in 2010, the following three measures groups were available for reporting through claims or registries: ischemic vascular disease (six measures), hepatitis C (eight measures), and community-acquired pneumonia (four measures). The Physician Quality Reporting System also introduced three new measures groups reportable only through a registry: coronary artery disease (five measures), heart failure (six measures), and HIV/AIDS (eight measures). Moreover, in an effort to simplify measures group reporting, the 2009 program year requirement to report consecutive patients was removed. That is, beginning in the 2010 program year, eligible professionals could report a measures group on 30 nonconsecutive beneficiaries—appropriate for the measures group—during the reporting period. This change applied to reporting measures groups through both claims and a registry. In 2011, one measures group reportable through claims or a registry was added—asthma (four measures)—and reporting measures groups through claims was reduced to require 50% of eligible instances rather than 80%.

As shown in Tables 6 and 7, CMS continued to expand and refine the avenues for participation options in recent years. For example, the GPRO and EHR options added in 2010 offered new opportunities for participation; like registries, these options do not rely on QDCs. The GPRO is an option for group practices with at least 200 eligible professionals (i.e., NPI). CMS further expanded the Physician Quality Reporting System in 2011 by adding the GPRO II reporting mechanism for smaller practices (i.e., between 2 and 199 eligible professionals).

Table 6. Summary of Reporting Options in the Physician Quality Reporting System (2009 to 2011).

	Physician Quality Reporting System		
	2009	2010	2011
Claims	Yes	Yes	Yes
Individual Measures	Yes	Yes	Yes
Measures Groups	Yes	Yes	Yes
Registry	Yes	Yes	Yes
Individual Measures	Yes	Yes	Yes
Measures Groups	Yes	Yes	Yes
Electronic Health Record (EHR)	No	Yes	Yes
Group Practice Reporting Option (GPRO)	No	Yes	Yes
Group Practice Reporting Option II (GPRO II)	No	No	Yes

Reporting quality information for practices who participated through the GPRO differs from reporting for eligible professionals who participated individually. A group practice that wanted to participate through the GPRO nominated their practice. Among practices that met requirements and were approved to participate through the GPRO, CMS provided a database containing a sample of patients with select patient demographic and utilization characteristics. The practices were responsible for completing data fields to report whether certain quality actions were performed for 26 measures for the selected patients. This database included four disease modules (i.e., diabetes mellitus, heart failure, coronary artery disease, and hypertension) and four preventive care measures. Practices had to report a minimum of 411 patients per disease module and preventive care measure or all eligible patients if the practice had fewer than 411 patients for a given module.

In addition to expanding options through which eligible professionals could participate, a reporting criterion for receiving an incentive was simplified. That is, the 2011 program year requires eligible professionals who report individual measures or measures groups through claims to report at least 50% of eligible instances, which decreased from 80%. Otherwise, the basic incentive eligibility rules remained the same in 2010 and 2011. Moreover, the Measure Applicability Validation (MAV) process continued, which allows eligible professionals who were eligible for fewer measures (e.g., less than 3) to qualify for an incentive.

MAV was applied for eligible professionals who satisfied the reporting criteria (e.g., 80% in 2010) for one or two individual measures and did not report other measures. The process then determines whether they could have reported additional clinically-related measures through two tests. First, the clinical relation test checks for any eligible instances on related measures. Second, the minimum threshold test checks for a certain number of eligible instances for those measures the eligible professional could have reported based on the clinical relation test.[7] Eligible professionals who satisfied the reporting criteria for one or two individual measures and

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

did not satisfy the MAV process did not qualify for an incentive because they could have reported additional measures. Conversely, eligible professionals who satisfied both the reporting criteria for one or two individual measures and the MAV process could qualify for an incentive.

Finally, as shown in Table 7, for eligible professionals who qualified for an incentive, the payment in the 2010 program year was 2% of estimated Medicare Part B PFS allowed charges for covered professional services furnished by the eligible professional in the applicable reporting period. Per the Affordable Care Act, the incentive percentage is 1% for the 2011 Physician Quality Reporting System. However, beginning in 2011, physicians have the opportunity to receive an additional 0.5% incentive by participating in a qualified Maintenance of Certification program. Specifically, to qualify for this additional 0.5% incentive, an eligible professional must complete the following:

- Satisfy the reporting criteria, without regard to option, on quality measures under the Physician Quality Reporting System, for a 12-month reporting period either individually or as part of a selected group practice.

  AND

- More frequently than is required to qualify for or maintain board certification, participate in a Maintenance of Certification Program.

  AND

- More frequently than is required to qualify for or maintain board certification, successfully complete a qualified Maintenance of Certification Program practice assessment.

Table 7. Summary of Physician Quality Reporting System Incentives, Measures and Reporting Criteria (2009 to 2011).

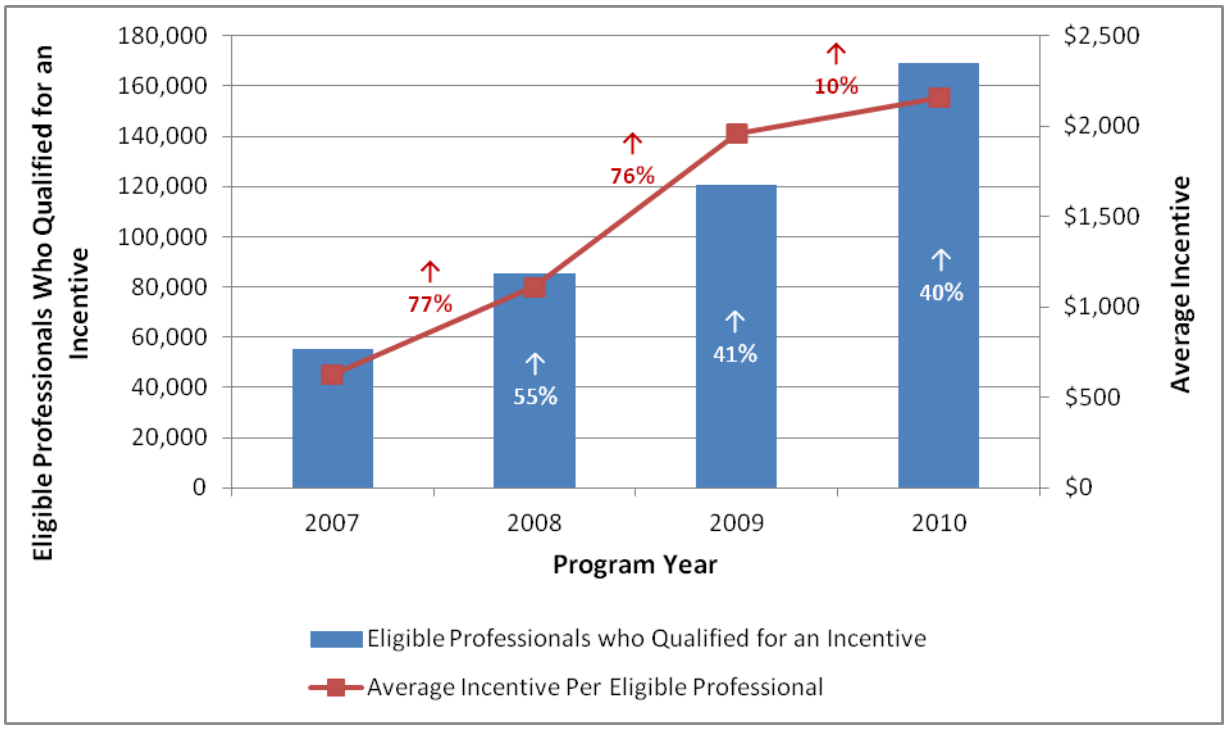
	2009	2010	2011
Incentive Percent	2.0%	2.0%	1.0%
Total Number of Individual Measures and Measures Groups	152 Clinical Measures 1 Structural Measure 7 Measures groups	178 Clinical Measures 1 Structural Measure 13 Measures groups	198 Clinical Measures 1 Structural Measure 14 Measures groups
Individual Measures Reporting Criteria	3 measures (or 1-2 measures subject to MAV) and 80% of eligible instances (registry has to report a minimum of 3 measures)	3 measures (or 1-2 measures subject to MAV) and 80% of eligible instances (registry has to report a minimum of 3 measures)	3 measures (or 1-2 measures subject to MAV) and 50% of eligible instances (registry has to report a minimum of 3 measures and 80% of eligible instances)
Reporting Period	12 Months (Jan 1 – Dec 31) 6 Months (July 1 – Dec 31)	12 Months (Jan 1 – Dec 31) 6 Months (July 1 – Dec 31)	12 Months (Jan 1 – Dec 31) 6 Months (July 1 – Dec 31)
Measures Group Reporting Criteria	Report on all measures in at least 1 MG for: • 80% eligible Medicare patients (min of 15 or 30 patients) or 30 consecutive patients (non-Medicare patients accepted for registry-based reporting only)	Report on all measures in at least 1 MG for: • 80% eligible Medicare patients (min of 8 or 15 patients) or 30 patients (non-Medicare patients accepted for registry-based reporting only)	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 Medicare patients

B. Incentive Payments

The incentive for the 2010 Physician Quality Reporting System was 2.0% of estimated Medicare Part B PFS allowed charges for covered professional services furnished by the eligible professional (professional and technical services) during the reporting period. Overall, a total of $391,635,494.99 in incentives were paid encompassing 168,843 eligible professionals and 19,232 practices during the 2010 program year.[8,9] Due in part to the increased number of measures and reporting options—including the introduction of the GPRO—and the growth in Part B PFS allowed charges, CMS's total 2010 incentive payments to successful participants were 65% higher than in 2009 ($236,696,431.85).

The average payment for the 2010 Physician Quality Reporting System was $2,157 per eligible professional and $20,364 per practice. Figures 8 and 9 show how the average incentive and the numbers of eligible professionals and practices earning incentives grew between 2007 and 2010.

Figure 8. Number of Eligible Professionals who Qualified for a Physician Quality Reporting System Incentive and Average Amounts (2007 to 2010).

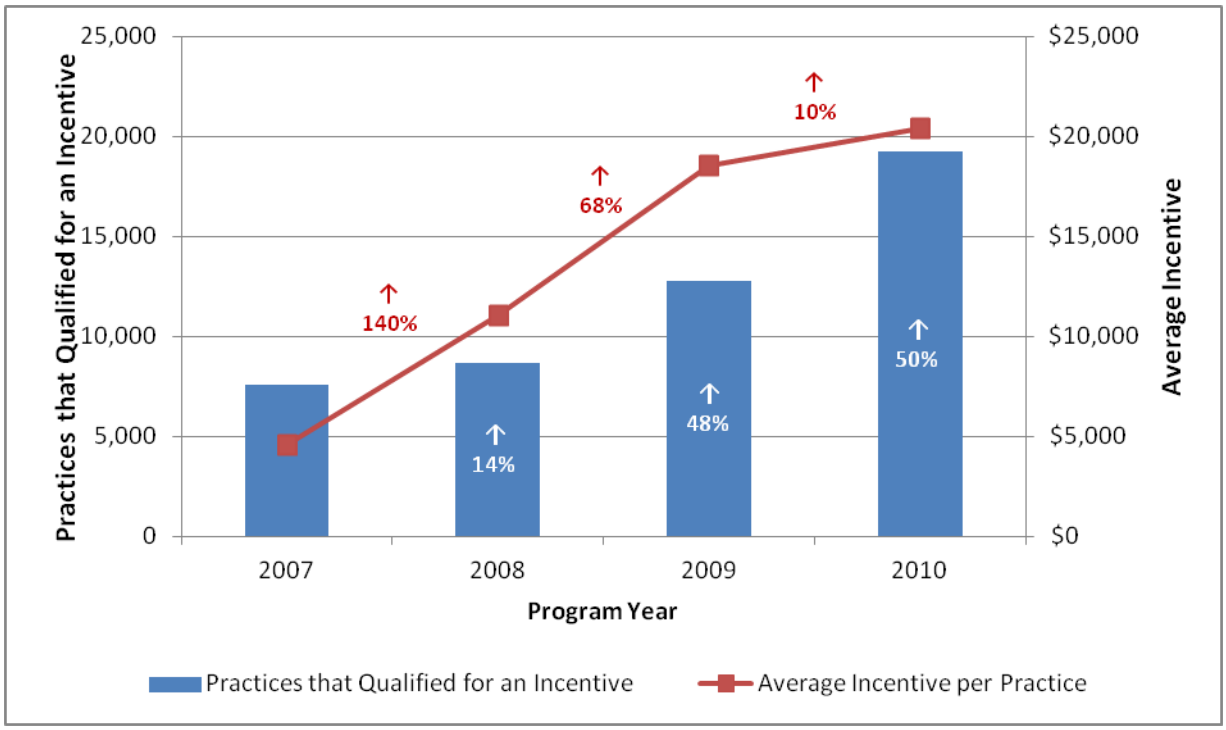


Note for Figure 8: Includes all individual reporting methods (i.e., claims, registry and EHR).

[8] Eligible professionals who met incentive eligibility criteria but had no Medicare Part B PFS charges during the reporting period had an incentive amount of $0.00. These eligible professionals were not included in counts of those who qualified for an incentive in this report. For additional explanation, please see the Appendix.

[9] Another 24,823 eligible professionals were encompassed within 35 practices that participated and qualified for an incentive through the GPRO; these eligible professionals did not participate individually and are not included in results describing individual eligible professionals.

Figure 9. Number of Practices that Qualified for a Physician Quality Reporting System Incentive and Average Amounts (2007 to 2010).



Note for Figure 9: Because incentive payments are distributed at the practice level, a practice was defined as qualifying for an incentive if at least one eligible professional within that practice qualified for an incentive through an individual option (i.e., claims, registry or EHR). These numbers also include practices that qualified for an incentive through the GPRO. Reporting results at the practice level are another indication of growth of the program.

Total incentive payments by specialty under the Physician Quality Reporting System is determined both by number of eligible professionals within the specialty who qualify for an incentive and by total Medicare Part B PFS allowed charges. Therefore, variations in total incentive payments by specialty reflect differences both in incentive eligibility rates and in Medicare Part B PFS allowed charges. Appendix Table A2 displays the distribution of incentive amounts by specialty.

The average potential incentive that could have been earned if 100% of individual eligible professionals participated and were incentive eligible was also explored. This was calculated by summing the total 2010 Medicare PFS allowed charges for covered professional services furnished during the 12-month reporting period for all individual eligible professionals who could have participated in 2010, dividing by the number of those individual eligible professionals, and taking 2.0% of this value. These results can be found in Appendix Table A3 and are presented for each specialty. Overall, the average potential incentive was over $1,500 and exceeded $3,000 for 12 specialties.

C. Participation

How to Participate

CMS provided multiple resources on the Physician Quality Reporting System website (www.cms.gov/PQRS/) to assist eligible professionals who choose to participate in the program. The *2010 Implementation Guide* gave guidance on how to determine which measures to report, reporting options, and claims-based reporting principles. CMS also provided Frequently Asked Questions (FAQ's) covering a wide range of topics regarding the program.

In 2010, there were 11 options for submitting data to the Physician Quality Reporting System (compared to 9 in 2009):

1. Claims-Based Individual Measures 12-months. Eligible professionals could have reported QDCs for 129 individual measures via claims. To qualify for an incentive, they had to report at least 80% of eligible instances in which the measures were reportable on at least 3 measures (or 1 or 2 measures, if fewer than 3 measures applied, subject to the measure applicability validation [MAV] review as described above); the 12-month reporting period was from January 1 to December 31, 2010.

2. Claims-Based Individual Measures 6-months. This option had the same reporting criteria as the preceding claims-based individual measures option (i.e., over 12-months) except with a 6-month reporting period from July 1 to December 31, 2010.

3. Claims-Based Measures Groups - 80% Patients 12-months. Eligible professionals could have reported all applicable measures within any of 13 measures groups. To be incentive eligible, they had to report all applicable measures for at least one measures group on at least 80% of their applicable Medicare Part B fee-for-service (FFS) patients; a minimum of 15 patients was required. The 12-month reporting period was from January 1 to December 31, 2010.

4. Claims-Based Measures Groups - 80% Patients 6-months. This option had the same reporting criteria as the preceding claims-based measures groups (i.e., over 12-months) with the following two exceptions: a minimum of 8 patients and a 6-month reporting period from July 1 to December 31, 2010.

5. Claims-Based Measures Groups - 30 Patients 12-months. Eligible professionals could have reported all applicable measures within any of the 13 measures groups. To be incentive eligible, they had to report all applicable measures for at least one measures group on at least 30 Medicare Part B FFS patients; the 12-month reporting period was from January 1 to December 31, 2010. This replaced the 2009 requirement that eligible professionals report on 30 *consecutive* patients.

6. Registry-Based Reporting - Individual Measures 12-months. Eligible professionals could have submitted data through a qualified registry. To be incentive eligible, they had to report on at least 3 measures and report each measure in at least 80% of eligible instances during the 12-month reporting period from January 1 to December 31, 2010.

7. Registry-Based Reporting - Individual Measures 6-months. This option had the same reporting criteria as the preceding registry-based individual measures option (i.e., 12-months) except with a 6-month reporting period from July 1 to December 31, 2010.

8. Registry-Based Reporting – Measures Groups 80% Patients 12-months. Eligible professionals could have submitted data through a qualified registry. To be incentive eligible, they had to report all applicable measures for at least one measures group on at least 80% of applicable Medicare Part B FFS patients seen during the reporting period; a minimum of 15 patients was required. The 12-month reporting period was from January 1 to December 31, 2010.

9. Registry-Based Reporting – Measures Groups 80% Patients 6-months. This option had the same reporting criteria as the preceding registry-based measures groups 80% option (i.e., 12-months) with the following two exceptions: a minimum of 8 Medicare Part B FFS patients and a 6-month reporting period from July 1 to December 31, 2010.

10. Registry-Based Reporting – Measures Groups 30 Patients 12-months. Eligible professionals could have submitted 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 include some, but not be exclusively, nonMedicare patients. The 12-month reporting period was January 1 to December 31, 2010. This replaced the 2009 requirement that eligible professionals report on 30 *consecutive* patients.

11. Electronic Health Records 12-months. Eligible professionals could have submitted data through a qualified EHR vendor. To be incentive eligible, they had to report at least 3 of 10 available EHR measures for at least 80% of applicable Medicare Part B FFS patients seen by the eligible professional during the 12-month reporting period from January 1 to December 31, 2010.

As described in the previous section, practices that self-nominated and were approved for participation through the GPRO were required to submit data through a database provided by CMS, and had to report at least 411 patients per each of four disease modules and a preventive care measure.

Participation Results

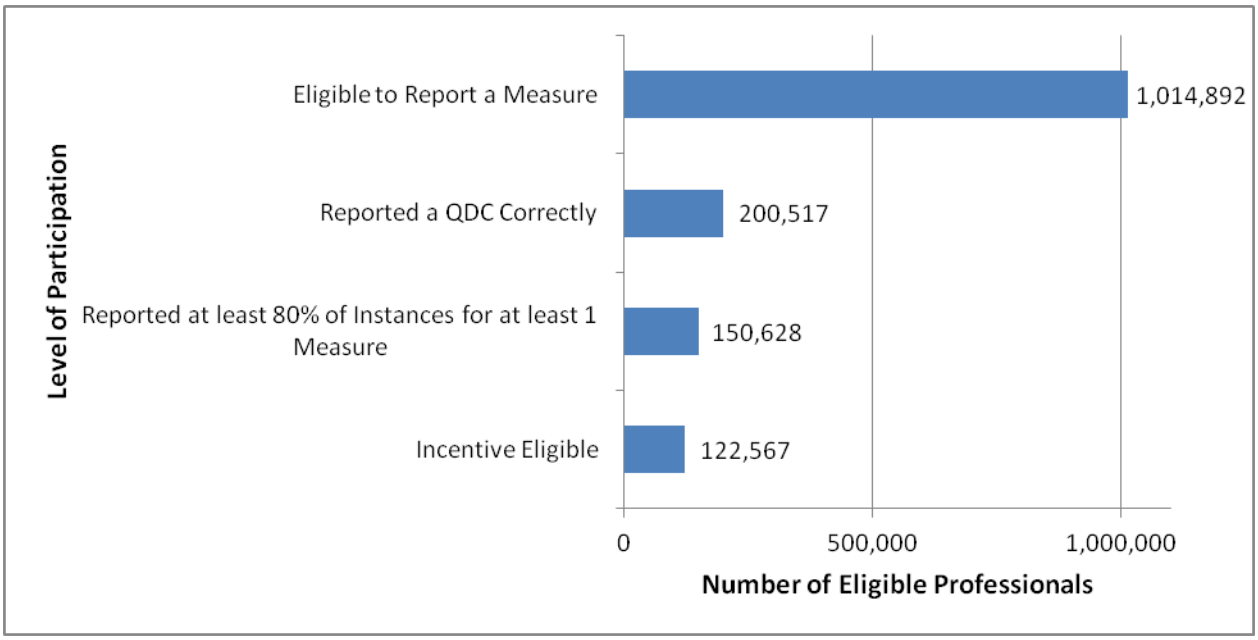
In 2010, there were 1,017,644 professionals eligible to participate in the Physician Quality Reporting System across all approaches.[10] The majority of professionals were eligible to participate via claims-based individual measures (1,014,892). Appendix Table A4 presents characteristics of eligible professionals for the 2010 Physician Quality Reporting System. Appendix Table A5 presents the number of eligible professionals who could have participated through any reporting option (i.e., individual measures or measures groups through claims, registry or EHR); this information is presented by specialty for the 2007 to 2010 program years.

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

As shown in Figure 3 and Table 5, each year of program operation has seen growth in participation across all reporting options. Overall, 244,145 eligible professionals (24%) participated in the 2010 Physician Quality Reporting System. Of these eligible professionals, 16,596 used either more than one submission option (EHR, claims, or registry) or reporting option (individual measures or measures groups). Appendix Table A6 shows that participation varied by reporting option and ranged from 19.7% of all eligible professionals reporting via the claims-based individual measures to 0% of all eligible professionals participating via EHR.[11] Historically, the overwhelming majority of professionals participated via the claims-based individual measure reporting option; however, participation via registries and the measures groups reporting option has grown since their introduction in 2008.

Figure 10 shows the level of participation for the claims-based individual measure reporting option in 2010. While over one million professionals were eligible to participate in the Physician Quality Reporting System in 2010, about 1 in 5 professionals participated by submitting at least one QDC without error. Ultimately, about 12% of the professionals eligible to submit claims-based individual measures to the Physician Quality Reporting System qualified for an incentive in 2010. Among all eligible professionals attempting to submit a QDC (N=208,133), about 4% submitted all invalid QDCs (N=7,616) (no table). Incentive eligibility and payments are described in greater detail in subsequent sections of this report.

Figure 10. Summary of Individual Measures Reported through the Claims Option for the Physician Quality Reporting System (2010).



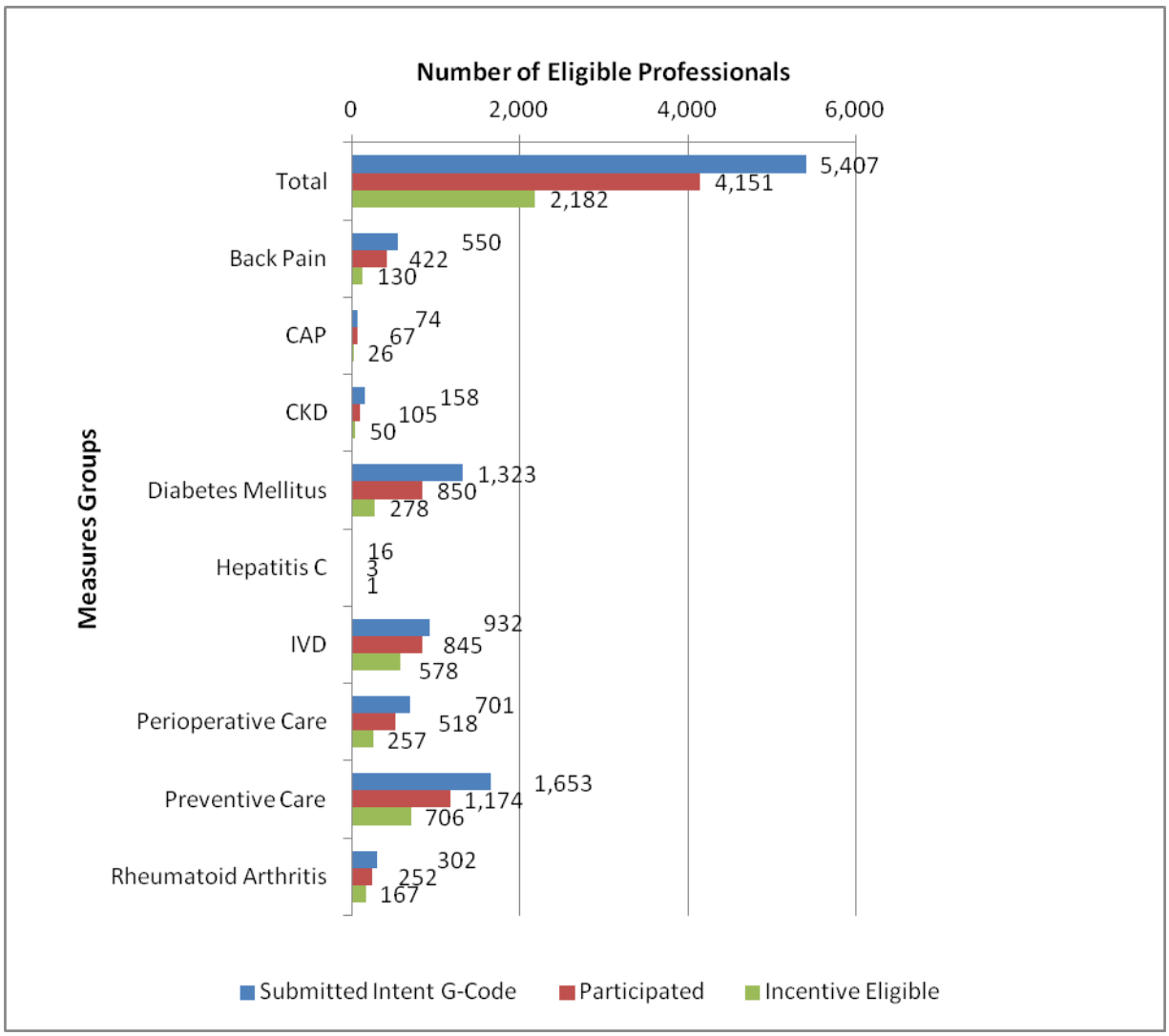
Note for Figure 10: Results included both 12-month and 6-month individual measures claims options.

[11] There were 14 eligible professionals who participated via EHR, which rounded down to 0%.

Use of Measures Groups and Registries

The number of measures groups in the Physician Quality Reporting System expanded from 4 to 13 between 2008 and 2010. The number of eligible professionals who participated via claims-based measures groups option grew nearly three-fold between 2008 and 2010. Figure 11 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 had the most eligible professionals submitting QDCs and the most eligible professionals earning an incentive payment (Figure 11).

Figure 11. Summary of Measures Groups Reported through the Claims Option for the Physician Quality Reporting System (2010).



Note for Figure 11: Results were restricted to measures groups through the claims option. Abbreviations: community-acquired pneumonia (CAP), chronic kidney disease (CKD), and ischemic vascular disease (IVD).

Participation in the registry-based, measures group reporting option grew at an even more rapid rate over the same period; the number of eligible professionals participating in registry measures groups increased more than five-fold between 2008 and 2010. The preventive care and diabetes measures groups had the largest number of eligible professionals submitting data via registry. These two measures groups are broadly applicable to the Medicare population and are applicable to two of the most common specialties (Family Medicine and Internal Medicine) reporting measures groups.

Table 8. Registries that Submitted Data on Behalf of the Most Eligible Professionals for the Physician Quality Reporting System or the eRx Incentive Program (2010).

Registry Name	Eligible Professionals Submitted by Registry
DocSite	7,195
Epic Systems Corporation	3,239
Central Utah Informatics	3,223
Outcome PQRI Registry	3,149
NextGen Registry	2,769
Wisconsin Collaborative for Healthcare Quality	2,717
CECity	2,551
GE Healthcare	2,437
Allscripts	2,344
MD Interactive	1,959

The use of registry reporting also increased from 2008 to 2010. In 2008, 31 qualified registries submitted data on behalf of eligible professionals, and in 2010, 89 qualified registries submitted data. Table 8 displays the registries that submitted data for the largest number of eligible professionals in 2010.[12] 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.

Challenges to Participation and Satisfactorily 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 80% of eligible instances, and (3) QDC submission errors. For example, QDC submission errors encompass submitting a QDC on a claim that did not have a qualifying diagnosis or the appropriate patient age, or submitting an incorrect Healthcare Common Procedure Coding System (HCPCS) code. Eligible professionals who submitted data for fewer than three claims-based individual measures also had to pass the MAV process to confirm they had fewer than three applicable measures. About one quarter of eligible professionals (24%) submitting claims data were subject to the MAV process in 2010.[13] In 2010, roughly 4% of those subject to the

[12] A complete listing of qualified registries available for the 2011 Physician Quality Reporting System can be found at www.cms.gov/PQRS/Downloads/2011_Qualified_Registries_Posting_10-04-2011.pdf

[13] More information on the MAV process is available on the Physician Quality Reporting System website under the Analysis and Payment page: http://www.cms.gov/PQRS/25_AnalysisAndPayment.asp#TopOfPage

MAV process were not incentive eligible, which was only about 1% of eligible professionals who participated.

CMS posts the rates of QDC errors on the Physician Quality Reporting System website.[14] Overall, 56,479,724 QDCs were submitted in 2010, of which about 19% were invalid (no table). These errors occurred when a QDC was submitted on a claim that did not have required information (e.g., diagnosis, procedure, gender) for that measure. An invalid QDC could occur, for example, if an eligible professional submits a QDC on an ineligible claim. An ineligible claim is one that lacks the necessary combination of diagnosis and procedure codes to identify the measure denominator. Because ineligible claims are not included in the measure denominator, QDC errors do not adversely affect an eligible professional's reporting rate.[15] However, proactive monitoring and reporting of QDC errors can provide eligible professionals with information on the most common errors in reporting, which they can use to improve.

The most common QDC error was where the eligible professional reported a QDC on a claim that did not also have the required procedure code (HCPCS). Among 56,479,724 QDC submissions for all measures in 2010, 11.6% had an incorrect HCPCS code, 4.1% had an incorrect diagnosis, 1.9% had both an incorrect HCPCS and diagnosis, 2.1% had an age mismatch, and 0.5% had neither the necessary diagnosis code nor the necessary procedure code.[16]

Though most measures reported had low rates of QDC errors, some measures reported had relatively high QDC error rates. For example, 90% of QDCs reported for measure #40 (Management Following Fracture) had a mismatch between the QDC and the diagnosis on the claim. Appendix Tables A14 through A16 highlight measures with high rates (greater than 20%) of specific QDC errors. It is recommended that eligible professionals double check the measure specifications to ensure accurate submission, especially if they are submitting any of these measures with higher rates of submission errors.

Participation by Specialty[17]

Many measures in the Physician Quality Reporting System apply to Emergency Medicine and Family Practice, providing numerous opportunities for eligible professionals in these specialties to report on their Medicare patients. Of eligible professionals who participated through the claims-based individual measure reporting option, emergency physicians had the largest representation among all specialties and also had a high rate of participation (65%). Hospital-

[14] For 2011, see the Physician Quality Reporting System website on the Analysis and Payment page. For prior years, see the Physician Quality Reporting system website and refer to the specific program year page (http://www.cms.gov/pqrs/).

[15] The reporting rate is the number of instances an eligible professional reported (e.g., a valid QDC) divided by the number of eligible instances on which they could have reported.

[16] More detail on the frequency of specific QDC errors can be found at http://www.cms.gov/PQRS/2010/

[17] 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.

based practices most likely have processes in place to capture clinical data accurately, therefore allowing quicker uptake of reporting quality measure data. Family practitioners also had a very large number of professionals submitting, but the percentage of eligible family practitioners submitting was lower than average (Table 9). Appendix Table A7 shows eligibility and participation rates by specialty across all reporting options. In addition, participation rates by specialty and submission option for 2007 through 2010 can be found in Appendix Tables A8 through A11.

Table 9. Specialties with the Largest Number of Eligible Professionals who Participated by Reporting Individual Measures through the Claims Option for the Physician Quality Reporting System (2010).

Specialty	Eligible Professionals	Eligible Professionals who Participated	% of Eligible Professionals who Participated
Emergency Medicine	49,278	32,030	65.0%
Anesthesiology	42,125	20,040	47.6%
Family Practice	91,533	14,778	16.1%
Radiologist	37,511	14,554	38.8%
Internal Medicine	92,424	14,427	15.6%
Nurse Anesthetist	41,199	14,274	34.7%
Physician Assistant	41,876	9,529	22.8%
Other Eligible Professionals	43,711	7,595	17.4%
Ophthalmology	18,917	7,555	39.9%
Optometry	31,028	6,949	22.4%

Note for Table 9: Results were restricted to individual measures reported through the claims option.

The specialties with the largest number of eligible professionals who submitted measures groups are listed in Table 10. Internal medicine and family practitioners had the highest numbers of submissions of claims-based measures groups.

Table 10. Specialties with the Largest Number of Eligible Professionals who Participated by Reporting Measures Groups through the Claims Option for the Physician Quality Reporting System (2010).

Specialty	Eligible Professionals Who Participated
Internal Medicine	895
Family Practice	759
Cardiology	559
Orthopedic Surgery	285
Other Eligible Professionals	222
Rheumatology	204
Physical/Occupational Therapy	158
Nurse Practitioner	153
General Surgery	140
Physician Assistant	109

Note for Table 10: Results were restricted to measures groups reported through the claims option.

Table 11. Specialties with the Largest Number of Eligible Professionals who Participated in the Registry Option for the Physician Quality Reporting System (2010).

Specialty	Professionals Eligible	Eligible Professionals who Participated	% of Eligible Professionals Who Participated
Family Practice	91,533	11,072	12.1%
Internal Medicine	92,424	10,256	11.1%
Cardiology	23,768	4,438	18.7%
Nurse Practitioner	48,603	2,829	5.8%
Other Eligible Professionals	43,711	2,190	5.0%
Physician Assistant	41,876	2,024	4.8%
Radiologist	37,511	1,712	4.6%
Nephrology	7,997	1,547	19.3%
Obstetrics/Gynecology	29,727	1,500	5.1%
Orthopedic Surgery	20,662	1,407	6.8%

Note for Table 11: Results were restricted to individual measures and measures groups reported through the registry option.

Participation through registries was most common among family practitioners, internal medicine, and cardiology physicians (Table 11).

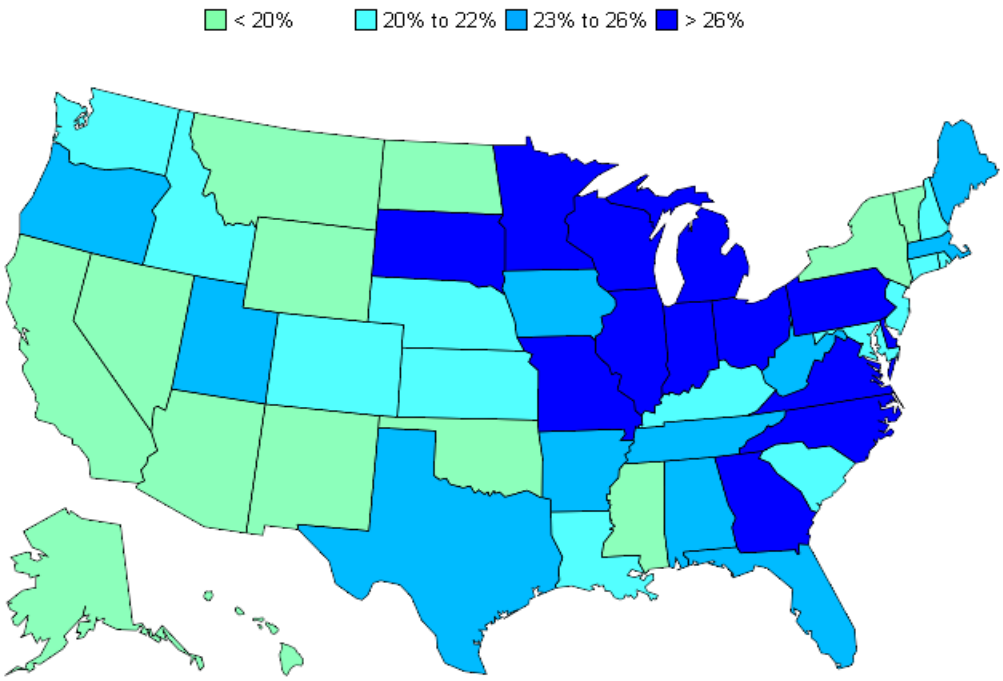
Among eligible professionals in practices participating in the Physician Quality Reporting System through the GPRO (N=24,823), the most common eligible professional specialties were internists, family practitioners, nurse practitioners, physician assistants and radiologists (representing 12%, 8%, 7%, 6% and 5% of all eligible professionals encompassed within

practices participating in the Physician Quality Reporting System through the GPRO, respectively) (no table).

Geographic Variation in Participation

Figure 12 demonstrates the geographic variation in participation in the 2010 Physician Quality Reporting System.[18] Participation rates were highest in Wisconsin (37%) and North Carolina (33%). Participation was lowest (10% or lower) in Alaska and Vermont. Detailed state-by-state results are available in Appendix Table A12.

Figure 12. Geographic Distribution of Percent of Eligible Professionals who Participated in the Physician Quality Reporting System (2010).



Note for Figure 12: Results included all individual participation options (i.e., claims, registry and EHR).

Participation by Measure

Many measures in the Physician Quality Reporting System were selected because they were applicable to a wide range of eligible professionals and Medicare beneficiaries. The measures applicable to the highest number of eligible professionals were preventive measures (Table 12). These measures do not require a specific diagnosis.

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

Table 12. Individual Measures Reportable by the Largest Number of Eligible Professionals for the Physician Quality Reporting System (2010).

Measure	Eligible Professionals
#124 HIT - Adoption/Use of EHRs	761,872
#128 Universal Weight Screening and Follow-Up	704,404
#130 Documentation of Current Medications	691,221
#173 Preventive Care and Screening: Unhealthy Alcohol Use – Screening	662,216
#114 Inquiry Regarding Tobacco Use	660,867
#115 Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	660,348
#47 Advance Care Plan	630,016
#154 Falls: Risk Assessment	607,967
#110 Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years and Older	575,225
#111 Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	569,814

Note for Table 12: Results included the claims, registry and EHR reporting options.

Table 13 lists the measures reported by the largest number of eligible professionals. Although a large number of eligible professionals reported these measures, several measures were submitted by 10% or fewer of eligible professionals for whom the measure was applicable, notably measure #124 (Adoption/Use of EHR), measure #1 (Diabetes Mellitus: Hemoglobin A1c Poor Control) and measure #2 (Diabetes Mellitus: Low Density Lipoprotein Control). Although measure #124 was only reported by 7% 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 A13 displays the percent of eligible professionals who reported each measure and the mean reporting rate for each measure reported through claims.

Table 13. Individual Measures Reported by the Largest Number of Eligible Professionals in the Physician Quality Reporting System (2010).

Measure	Eligible Professionals who Participated	% of Eligible Professionals who Participated
#124 HIT - Adoption/Use of EHRs	52,488	6.9%
#54 ECG Performed for Non-Traumatic Chest Pain	39,683	57.0%
#57 Community-Acquired Bacterial Pneumonia (CAP): Assessment of Oxygen Saturation	39,059	19.2%
#30 Timing of Prophylactic Antibiotics - Administering Physician	35,542	43.8%
#58 Community-Acquired Bacterial Pneumonia (CAP): Assessment of Mental Status	35,112	17.3%
#56 Community-Acquired Bacterial Pneumonia (CAP): Vital Signs	34,802	17.1%
#55 ECG Performed for Syncope	33,553	62.0%
#1 Hemoglobin A1c Poor Control	32,925	10.1%
#114 Inquiry Regarding Tobacco Use	32,024	4.8%
#2 Low Density Lipoprotein Control	30,823	9.4%

Note for Table 13: Results included claims, registry and EHR options.

Table 14 presents information on the top 5 measures submitted by each specialty, identified by measure number. Overall, among eligible professionals with an MD/DO, the top five measures reported were: #124 (Adoption/Use of EHR), #1 (Diabetes Mellitus: Hemoglobin A1c Poor Control); #57 (Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia); #54 (ECG Performed for Non-Traumatic Chest Pain); and #2 (Diabetes Mellitus: Low Density Lipoprotein Control). Measure #124 was the most commonly reported measure.

Table 14. Most Reported Individual Measures for Each Specialty for the Physician Quality Reporting System (2010).

Specialty	Top 5 Measures Submitted				
	#1 (Top)	#2	#3	#4	#5
MD/DO	**124**	**1**	**57**	**54**	**2**
Allergy/Immunology	124	114	110	115	111
Anesthesiology	30	76	193	124	114
Cardiology	6	124	114	115	130
Colon/Rectal Surgery	20	23	22	124	21
Critical Care	51	114	124	52	76
Dermatology	136	137	138	124	114
Emergency Medicine	57	54	55	56	58
Endocrinology	1	2	3	124	119
Family Practice	1	2	3	124	114
Gastroenterology	124	113	114	130	185
General Practice	124	1	3	57	54
General Surgery	20	21	23	124	22

Specialty	Top 5 Measures Submitted				
	#1 (Top)	#2	#3	#4	#5
Geriatrics	1	2	3	124	110
Hand Surgery	124	20	21	114	23
Infectious Disease	124	110	111	130	114
Internal Medicine	1	2	3	124	6
Interventional Radiologist	145	195	10	76	147
Nephrology	124	122	121	123	135
Neurology	124	114	130	115	31
Neurosurgery	20	21	124	23	22
Nuclear Medicine	147	6	195	145	10
Obstetrics/Gynecology	124	114	112	39	48
Oncology/Hematology	69	70	67	124	72
Ophthalmology	14	12	18	117	140
Oral/Maxillofacial Surgery	114	115	20	22	173
Orthopedic Surgery	20	21	23	22	124
Other MD/DO	32	6	47	36	31
Otolaryngology	124	114	130	115	91
Pathology	99	100	124	114	1
Pediatrics	124	114	130	1	2
Physical Medicine	124	114	130	115	154
Plastic Surgery	124	114	20	23	21
Psychiatry	124	9	107	106	114
Pulmonary Disease	51	114	124	52	111
Radiation Oncology	105	104	156	102	71
Radiologist	10	195	145	146	147
Rheumatology	108	124	41	39	178
Thoracic/Cardiac Surgery	43	45	44	20	21
Urology	48	49	124	50	114
Vascular Surgery	20	21	22	124	158
Other Eligible Professionals	**30**	**124**	**130**	**54**	**114**
Agencies/Hospitals/Nursing and Treatment Facilities	54	124	3	57	55
Audiologist	124	130	190	114	110
Certified Nurse Midwives	124	114	112	130	110
Chiropractor	131	182	124	130	114
Clinical Nurse Specialists	124	114	1	2	3
Counselor/Psychologist	124	134	107	106	9
Dentist	114	124	130	20	115
Dietitian/Nutritionist	2	1	3	124	128
Nurse Anesthetist	30	193	76	113	20
Nurse Practitioner	124	1	2	3	114
Optometry	14	12	117	18	140

Specialty	Top 5 Measures Submitted				
	#1 (Top)	#2	#3	#4	#5
Other Eligible Professional	124	114	54	57	130
Physical/Occupational Therapy	131	154	130	155	128
Physician Assistant	54	57	58	56	124
Podiatrist	126	127	163	124	114
Registered Nurse	30	193	124	3	1
Social Worker	124	107	106	134	114
Unknown/Missing	124	30	6	56	57
Total	**124**	**30**	**57**	**1**	**54**

Note for Table 14: Please refer to the Appendix Table A1 for measure descriptions; results included claims, registry and EHR options.

D. Incentive Eligibility

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

The incentive eligibility criteria for the 2010 program year were as follows:

- 80% individual measures option: An eligible professional could report at least 80% of eligible instances for at least three measures; this criterion applied to the individual measures options for claims, registry and EHR. For the claims option only, an eligible professional could qualify for an incentive by reporting at least 80% of eligible instances on 1 or 2 measures (i.e., less than 3) if the MAV process was passed; the MAV process checked to ensure it was acceptable for an eligible professional to report less than 3 measures. Eligible professionals could report using this option for a 12-month (January 1 through December 31, 2010) or 6-month (July 1 through December 31, 2010) period.

- 80% of patients measures group option: Eligible professionals could report at least 80% of applicable Medicare Part B FFS patients for all applicable measures within the measures group; this criterion applied to claims and registry options. Eligible professionals could report using this option for a 12-month (January 1 through December 31, 2010) or 6-month (July 1 through December 31, 2010) period.

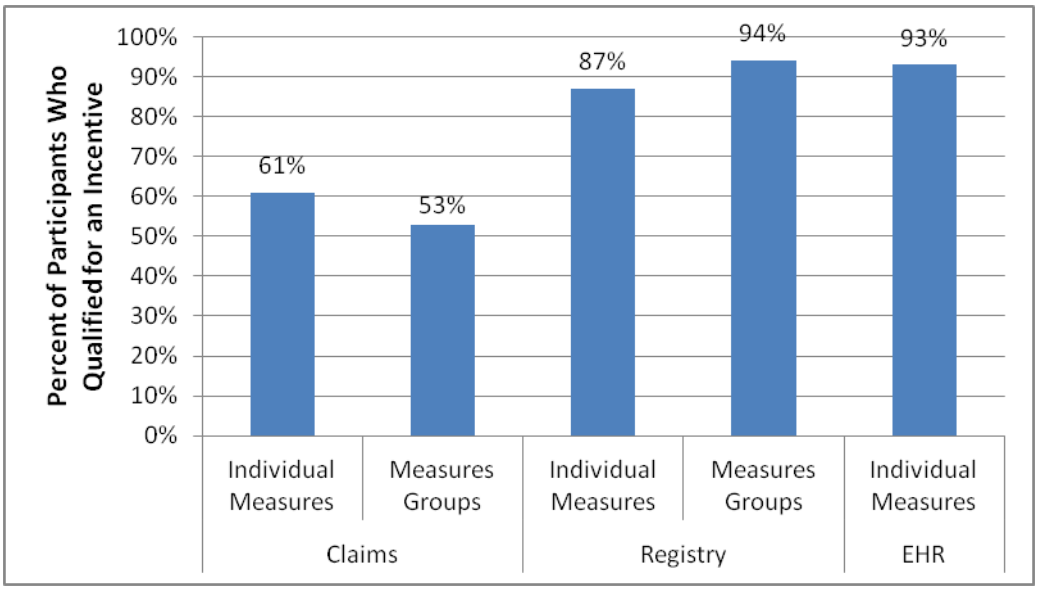
- 30 patients (count) option: An eligible professional could report all applicable measures within a measures group for at least 30 patients; this criterion applied to claims and registry options. While claims required all Medicare Part B FFS patients, registry allowed nonMedicare patients but could not be exclusively nonMedicare patients. Eligible professionals could report using this option for the 12-month (January1 through December 31, 2010) period.

Eligible professionals meeting the requirements for satisfactory reporting qualified for a bonus payment of 2% of CMS's estimated Medicare Part B PFS charges for covered professional services during the applicable reporting period in 2010.

Incentive Eligibility by Reporting Approach

Nearly 7 out of 10 eligible professionals who participated in the 2010 Physician Quality Reporting System qualified for an incentive (69%), considerably higher than the 2008 rate (56%) (Appendix Table A17). Between 2008 and 2010, the increase in the number of eligible professionals who qualified for an incentive varied widely by reporting approach. The number of eligible professionals who qualified for an incentive through either the claims or the registry measures groups options increased more than five-fold during this period, due in part to increases in the number of eligible professionals participating in these options and the proportion who qualified for an incentive during this period. In the 2010 program, the percent of eligible professionals who qualified for an incentive varied widely by option. Figure 13 shows percents were highest among those using registry reporting and lowest among those using claims-based measures groups. All 35 practices that participated through the GPRO qualified for an incentive payment (not shown).

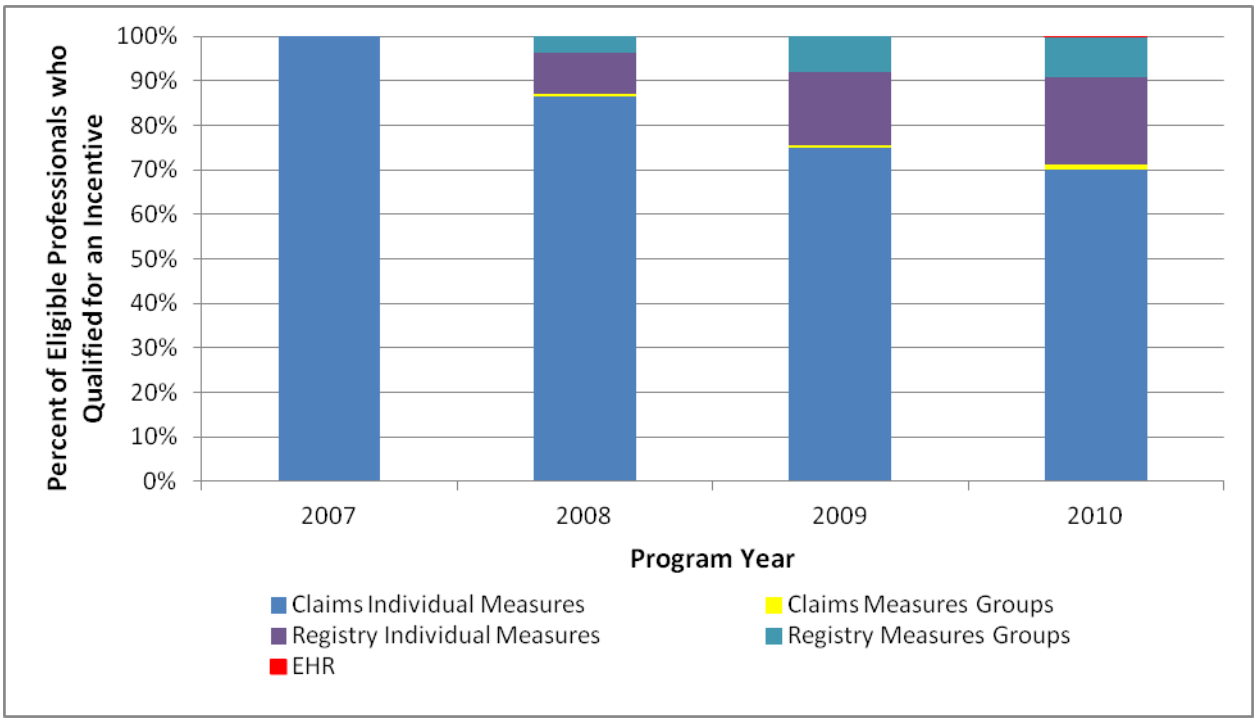
Figure 13. Incentive Eligibility Rate by the Physician Quality Reporting System Reporting Option (2010).



Notes for Figure 13: An eligible professional could be incentive eligible under more than one reporting option; but, could receive only one incentive payment. Incentive eligibility cannot be computed for individual eligible professionals in practices participating through the GPRO and are therefore not included in this figure. Only 14 eligible professionals participated through an EHR.

Between 2008 and 2010, the proportion of all eligible professionals who qualified for an incentive payment by reporting via registries grew, while the proportion of all eligible professionals qualifying for an incentive payment via the claims-based mechanisms declined (Figure 14). However, since more eligible professionals participated via claims reporting of individual measures, more eligible professionals earned an incentive under this option.

Figure 14. Distribution of Eligible Professionals who Qualified for an Incentive for the Physician Quality Reporting System by Participation Option (2007 to 2010).



Notes for Figure 14: An eligible professional could be incentive eligible under more than one reporting option but could receive only one incentive payment. Incentive eligibility cannot be computed for individual eligible professionals in practices participating through the GPRO and are therefore not included in this figure. Only 14 eligible professionals participated through an EHR.

Incentive Eligibility by Specialty

The specialties with the most eligible professionals who qualified for an incentive follow the same patterns as participation. Across all options, internists and family medicine physicians had more eligible professionals who qualified for an incentive relative to other specialties. For the claims-based individual reporting option, emergency physicians most commonly qualified for an incentive. Appendix Tables A18 through A21 present the percentage of eligible professionals from each specialty who qualified for an incentive by program year for each reporting option. Tables 15 through 17 display the specialties with the most eligible professionals who qualified for an incentive for each reporting approach.

Among the specialties with the most eligible professionals who qualified for an incentive through the claims-based individual reporting option, emergency medicine and physician assistants also had relatively high rates of incentive eligibility (Table 15).

Table 15. Specialties with the Largest Number of Eligible Professionals who Qualified for an Incentive by Reporting Individual Measures through the Claims Option for the Physician Quality Reporting System (2010).

Specialty	Eligible Professionals who Qualified for an Incentive	Eligible Professionals who Participated	% Who Qualified for an Incentive
Emergency Medicine	27,411	32,030	85.6%
Anesthesiology	12,743	20,040	63.6%
Nurse Anesthetist	9,539	14,274	66.8%
Radiologist	8,899	14,554	61.1%
Family Practice	7,857	14,778	53.2%
Physician Assistant	7,097	9,529	74.5%
Internal Medicine	6,871	14,427	47.6%
Other Eligible Professionals	4,486	7,595	59.1%
Ophthalmology	4,374	7,555	57.9%
Nurse Practitioner	4,352	6,721	64.8%

Note for Table 15: Results were restricted to individual measures reported through the claims option.

As seen in Table 16, incentive eligibility rates among some specialties that participated in the claims-based measures groups reporting option were lower than other reporting options (below 40%); however, cardiologists and rheumatologists had relatively high proportions of eligible professionals who qualified for an incentive. Each year additional measures groups were added to allow reporting of measures groups by more specialties.

Table 16. Specialties with the Largest Number of Eligible Professionals who Qualified for an Incentive by Reporting Measures Groups through the Claims Option for the Physician Quality Reporting System (2010).

Specialty	Eligible Professionals who Qualified for an Incentive	Eligible Professionals who Participated	% Who Qualified for an Incentive
Internal Medicine	545	895	60.9%
Cardiology	431	559	77.1%
Family Practice	308	759	40.6%
Orthopedic Surgery	171	285	60.0%
Rheumatology	138	204	67.6%
Other Eligible Professionals	120	222	54.1%
Nurse Practitioner	51	153	33.3%
Nephrology	48	91	52.7%
Physician Assistant	38	109	34.9%
General Surgery	37	140	26.4%

Note for Table 16: Results were restricted to measures groups reported through the claims option.

The incentive eligibility rates for registry reporting were quite high among the top specialties that participated. Although, other eligible professionals' incentive eligibility rates were lower than rates observed for MD/DO specialties (Table 17).

Table 17. Specialties with the Largest Number of Eligible Professionals who Qualified for an Incentive Using the Registry Option for the Physician Quality Reporting System (2010).

Specialty	Eligible Professionals who Qualified for an Incentive	Eligible Professionals who Participated	% Who Qualified for an Incentive
Family Practice	10,412	11,072	94.1%
Internal Medicine	9,368	10,256	91.3%
Cardiology	4,264	4,438	96.1%
Nurse Practitioner	2,356	2,829	83.3%
Other Eligible Professionals	1,850	2,190	84.5%
Physician Assistant	1,683	2,024	83.2%
Nephrology	1,485	1,547	95.9%
Orthopedic Surgery	1,331	1,407	94.6%
Obstetrics/Gynecology	1,314	1,500	87.6%
Dermatology	1,240	1,359	91.2%

Note for Table 17: Results were restricted to individual measures and measures groups reported through the registry option.

E. Clinical Performance Rates

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

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

Nonetheless, this section of the report aims to describe clinical performance rates and trends.[19] The Appendix Tables A22 and A23 provide reporting and performance information across program years. Changes in reporting and performance rates should be interpreted with caution because they include modifications to the Physician Quality Reporting System, such as new reporting options and participation methods and growth in number of participants. In an attempt to address one of these issues (i.e., changes on whom data was obtained), information is provided on a group of 56,106 eligible professionals who reported the same individual measure all four years of the program (i.e., 2007 to 2010). The Appendix Table A24 describes eligible professionals who consistently reported measures across successive program years. The Appendix Tables A25 to A27 describe performance information for varying years of eligible professionals who consistently reported a measure (i.e., 2, 3, or 4-years continuously).

Tables 18 and 19 display the measures with the largest percentage point decline and improvement in performance rate between 2007 and 2010 among eligible professionals who reported the same measure for four years. While this information attempts to account for changes in who participated, it does not account for other changes. In addition, as more measures have been added to the program, eligible professionals may start reporting data on measures that are more applicable to their practice. For instance, measures with the largest performance rate improvement shown in Table 19 could be affected by the inclusion of registry performance data. Registries, in some cases, incorporate processes that support eligible professionals' selection of appropriate measures, edits that help to ensure that measures are submitted accurately, and reminders that help providers meet the performance criteria of the measures.

Table 18. Individual Measures with the Largest Percentage Point Decrease in Performance Rate for the Physician Quality Reporting System (2007 and 2010).

Measure	2007 Performance Rate (%)	2010 Performance Rate (%)	Percentage Point Change 2007 – 2010
#40 Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	80.1%	61.8%	-18.3%
#39 Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	91.0%	79.5%	-11.6%
#7 Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)	96.4%	85.6%	-10.8%
#1 Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	11.2%	16.6%	-5.4%
#36 Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	80.0%	76.6%	-3.4%

Note for Table 18: Results included the claims, registry and EHR reporting options. Results were restricted to a group of eligible professionals who reported the same measure from 2007 to 2010. Measure #1 was an inverse measure where a lower performance rate indicated better performance. This

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

table includes measure performance among eligible professionals regardless of whether they met the 80% satisfactory reporting requirement.

Table 19. Individual Measures with the Largest Percentage Point Increase in Performance Rate for the Physician Quality Reporting System (2007 and 2010).

Measure	2007 Performance Rate (%)	2010 Performance Rate (%)	Percentage Point Improvement 2007 - 2010
#35 Stroke and Stroke Rehabilitation: Screening for Dysphagia	46.5%	87.3%	40.8%
#19 Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care	69.9%	93.9%	23.9%
#52 Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	78.4%	99.3%	20.8%
#68 Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	77.9%	98.4%	20.5%
#45 Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	81.6%	99.6%	18.0%

Note for Table 19: Results included the claims, registry and EHR reporting options. Results were restricted to a group of eligible professionals who reported the same measure from 2007 to 2010. This table includes measure performance among eligible professionals regardless of whether they met the 80% 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%, the ability to improve performance is limited. Table 20 displays the measures with the highest mean clinical performance rates in 2010.

Table 20. Individual Measures with the Highest Mean Performance Rates for the Physician Quality Reporting System (2010).

Measure	Mean Performance Rate (%)	#Eligible Professionals Submitting
#45 Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	99.4%	1,257
#124 Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	99.2%	52,488
#146 Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	1.1%	7,680
#100 Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	98.5%	4,334
#43 Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	97.9%	1,516
#99 Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	97.6%	4,550
#139 Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement	97.5%	3,919
#131 Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up	97.3%	6,157

Note for Table 20: Results included the claims, registry, and EHR reporting options. Measure #146 was an inverse measure where a lower performance rate indicated better performance. Measures #66 and #188 each had a mean performance rate of 100% but had too few eligible professionals for reliable reporting and are therefore not included in this table.

Some measures show particularly high rates of performance across all eligible professionals. Table 21 displays measures where at least 90 percent of the eligible professionals who reported a measure achieved performance at or above 90% in 2010. Appendix Table A28 is similar and displays the percent of eligible professionals who participated in a measure and had a performance rate at or above 90%.

Table 21. Individual Measures where at least 90% of Eligible Professionals who Participated had at least a 90% Performance Rate on the Physician Quality Reporting System Measure (2010).

Topic Measure	Percent of TIN/NPIs with >=90% Performance
#146 Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	98.8%
#124 Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	98.6%
#192 Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	97.3%
#139 Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement	96.5%
#45 Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	96.3%
#43 Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery	96.2%
#131 Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up	94.8%
#18 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	94.4%
#100 Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	93.7%
#58 Community-Acquired Pneumonia (CAP): Assessment of Mental Status	92.4%
#14 Age-Related Macular Degeneration (AMD): Dilated Macular Examination	91.7%
#141 Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	91.2%
#56 Community-Acquired Pneumonia (CAP): Vital Signs	90.4%
# 99 Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	90.2%
#55 12-Lead Electrocardiogram (ECG) Performed for Syncope	90.1%

Note for Table 21: Results included the claims, registry, and EHR reporting options. Measure #124 was not 100% due to registry data submission errors (i.e., not due to performance issues). Measures #146 and #192 were inverse measures where a lower performance rate indicated better performance; for these measures <= 10% was used (i.e., instead of >= 90%). This table includes measure performance among eligible professionals regardless of whether they met the 80% satisfactory reporting requirement. Measure #66 had high performance but too few submissions for reliable reporting and is therefore not included in this table.

GPRO Performance

Appendix Table A29 summarizes quality measure reporting and performance of the 35 practices participating in the 2010 program through the GPRO. GPRO participants reported aggregate results for 26 measures covering coronary artery disease, diabetes, heart failure, hypertension, and preventive care. Practices reported measures for, on average, over 400 eligible instances; a few CAD and heart failure measures were reported less often. The measures reported for the most eligible instances, on average, were for weight measurement among heart failure patients and blood pressure measurement. Performance rates on the measures ranged from a low of 55% for LDL-C control among diabetes patients to a high of 93% for hemoglobin A1c testing in diabetes patients. In general, performance on measures for conditions such as CAD and heart failure was higher (83% to 90%) than performance on preventive measures such as mammography, colorectal cancer screening, influenza immunization, and pneumonia vaccination (60% to 75%).

IV. ELECTRONIC PRESCRIBING (ERX) INCENTIVE PROGRAM

A. Background

Program Description

Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) authorized a new and separate incentive program—the Electronic Prescribing (eRx) Incentive Program—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:[20]

- 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.[21]
- Provide information related to lower cost and therapeutically appropriate alternatives (if any). (The availability of an e-prescribing system to receive tiered formulary information, if available, would meet this requirement for 2010.)
- 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 by virtue of the 2003 Medicare Modernization Act (MMA). Individual eligible professionals did not need to register to participate in the Physician Quality Reporting System to participate in the eRx Incentive Program. To participate in the eRx Incentive Program, eligible professionals could have reported data on the eRx quality measure on eligible Medicare Part B claims indicating a qualified eRx system was used. Beginning in 2010, individual eligible professionals also could submit data through a qualified registry or a qualified electronic health record (EHR) vendor to indicate use of a qualified eRx system. In addition, group practices were eligible to report data on the eRx quality measure through a GPRO using claims, registry, or EHR reporting options, if they self-nominated to report the eRx quality measure as a group and were approved to participate in the Physician Quality Reporting System.

[20] The eRx measure specification can be found at http://www.cms.gov/ERxIncentive.

[21] 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.

To participate in the 2010 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 PFS claim for an eligible instance. Eligible instances were defined as claims having one of a specific set of procedure codes.[22] 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. In 2010, there was one valid QDC for the eRx quality measure:

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

In addition to participating through claims, eligible professionals could participate through a qualified registry or EHR vendor.

To earn the incentive payment for the 2010 eRx Incentive Program, an individual eligible professional had to meet two criteria:

1. **Be a Successful Electronic Prescriber.** Individual eligible professionals had to report the eRx measure for at least 25 unique visits (eligible instances) during the reporting period. For group practices participating through the GPRO, the number of unique visits required was 2,500 during the reporting period.
2. **10% Incentive Eligibility 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 be at least 10% of the total allowed Part B 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.

ERx incentives are based on the percent (e.g. 2% in 2010) of total estimated Medicare Part B PFS allowed charges for covered professional services furnished by the eligible professional during the reporting period.

Program Evolution

After expanding the eRx incentive program in 2010, CMS did not make any changes to the reporting requirements for the 2011 program for individual eligible professionals (see Table 22). For group practices, CMS added a new GPRO (GPRO II) that is available to practices with between 2 and 199 eligible professionals; previously, only practices with 200 or more eligible professionals could participate in the original Physician Quality Reporting System GPRO (now known as GPRO I).

[22] 2010 denominator codes (CPT/HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, and G0109.

Table 22. Summary of eRx Incentive Program Requirements (2009 to 2011).

	eRx Incentive Program		
	2009	2010	2011
Incentive Payment	2%	2%	1%
Reporting Periods	January 1 – December 31	January 1 – December 31	January 1 – December 31
Reporting Mechanisms	Claims	Claims, Registry**, EHR**	Claims, Registry**, EHR**
Individual or GPRO	Individual Eligible Professionals only	Individual Eligible Professionals, Group Practices (GPRO)**	Individual Eligible Professionals, Group Practices I (GPRO I)**, Group Practices II (GPRO II)**
Quality-Data Code(s)	G8443, G8445, G8446	G8553	G8553
Successful Electronic Prescriber Reporting Requirement	50% of eligible instances	Individual Participation: At least 25 eligible events. GPRO: At least 2,500 eligible events.	Individual Participation: At least 25 eligible events. GPRO I: At least 2,500 eligible events. GPRO II: requirement varied by # 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)
Incentive Eligibility Threshold	At least 10% of total Medicare Part B PFS allowed charges from the eRx measure	At least 10% of total Medicare Part B PFS allowed charges from the eRx measure	At least 10% of total Medicare Part B PFS allowed charges from the eRx measure

*Note for Table 22:** Only group practices that qualified for the 2011 Physician Quality Reporting System GPROs were able to participate in the eRx Incentive Program GPRO. Only qualified registries and EHRs could be used as a reporting mechanism. The incentive eligibility threshold was the percent of Medicare Part B PFS charges that must be comprised of charges from eligible eRx instances.*

Overall, 696,663 eligible professionals could have participated in the eRx Incentive Program in 2010 compared to 669,691 in 2009. In addition, there were 27 qualified group practices that indicated their intent to participate through the GPRO in 2010; however, two of these practices did not participate (Table 5). In the first half of 2011, there were 612,762 professionals eligible for the eRx Incentive Program, 35 practices eligible for the GPRO I, and 35 practices eligible for

the GPRO II (not shown). Professionals are eligible for the eRx Incentive Program if they had at least one eligible instance for the eRx measure.

B. Incentive Payments

In 2010, CMS paid $270,895,539.52 in incentive payments that encompassed 65,857 eligible professionals and 18,713 practices (Table 5). The average incentive payment was $3,836.14 per eligible professional and $14,476.33 per practice (Table 23).

Table 23. eRx Incentive Payments (2009-2010).

	2009	2010
Average Incentive Payment per Eligible Professional	$3,060.92	$3,836.14
Average Incentive Payment per Practice	$14,500.62	$14,476.33
Total Incentive Amounts	**$148,007,815.60**	**$270,895,539.52**

Note for Table 23: Results for eligible professionals included the claims, registry and EHR reporting options. Results for practices included claims, registry, EHR and GPRO.

Appendix Table A30 presents the distribution of payments in 2010. The majority of 2010 incentive payments were paid to the top participating specialties—cardiology, internal medicine, ophthalmology, and family practice. Appendix Table A31 shows the average potential incentive by specialty (based on 2% of estimated total Medicare Part B PFS allowed charges for covered professional services furnished by eligible professionals during the reporting period) and the participation rate. Some specialties with relatively high potential incentives but relatively low participation included specialties with more difficulty meeting the 10% incentive eligibility threshold (e.g., interventional radiology, vascular surgery, radiation oncology, and radiology).

C. Participation

How to Participate

With one measure and one reporting period (January 1 through December 31, 2010), participating in the eRx Incentive Program was relatively straightforward. Eligible professionals did not have to enroll or file any intent to participate in the eRx Incentive Program. In 2010, eligible professionals or a group practice that participated through the eRx Incentive Program GPRO could use the claims-based option to report the one QDC indicating at least one prescription was generated using a qualified eRx system. Alternatively, eligible professionals could participate in the eRx Incentive Program through qualified registries or EHR vendors. To be a successful electronic prescriber, eligible professionals had to report the eRx quality measure in at least 25 eligible instances via one reporting option (i.e., claims, registry or EHR) during the reporting period. A practice participating through the GPRO had to report the eRx quality measure in at least 2,500 eligible instances.

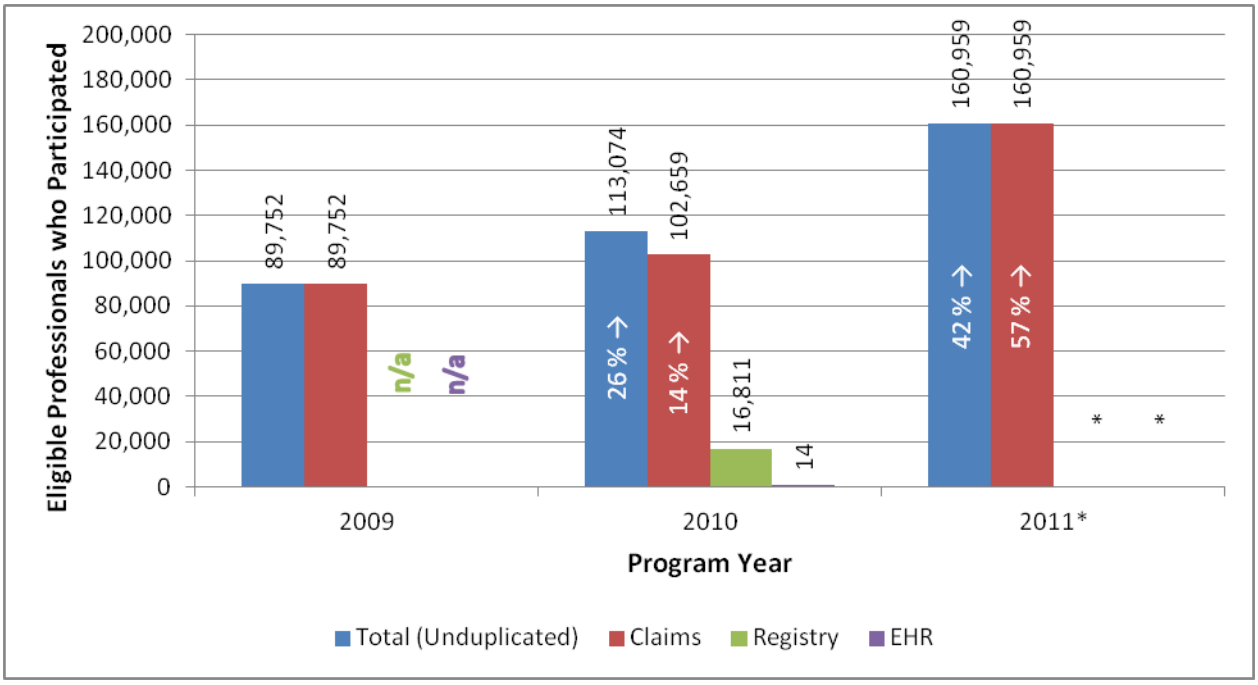
In 2010, there were 50 qualified registries and 5 qualified EHR vendors for the 2010 eRx Incentive Program; 45 registries and 1 EHR vendor submitted eRx quality measure information. Eligible professionals who chose to participate in the 2010 eRx Incentive Program using the

registry or EHR-based reporting options contacted the CMS-qualified registries or EHR vendors listed in the posted CMS qualified lists.[23]

Participation Findings

Overall, 113,074 eligible professionals (16.2% of those eligible) participated in the 2010 eRx Incentive Program (Figure 15), which was a 26% increase from 2009. In addition, 25 practices (out of 27 qualified by CMS to participate), encompassing 17,879 eligible professionals, participated in the eRx Incentive Program through the GPRO.

Figure 15. Number of Eligible Professionals who Participated in the eRx Incentive Program (2009 to 2011*).



*Notes for Figure 15: Results included participation under the claims, registry and EHR reporting mechanisms. *Results for 2011 are preliminary only; registry and EHR reporting options are not yet available.*

Although results for 2011 were incomplete, by June 2011, 160,959 eligible professionals (26.3% of those eligible) submitted data for the eRx measure through claims (Figure 15). In addition, at the time this report was prepared, there were 35 qualified groups submitting data on the eRx quality measure through GPRO I and 35 CMS-qualified groups submitting data through the GPRO II. Results for registry and EHR submissions were not yet available at the time this document was created.

In 2010, eligible professionals submitted a total of 9,221,718 eRx QDCs through claims, with an average of 90 QDCs submitted per eligible professional (data not shown). Nearly all (96.8%) of

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

these QDCs were correctly submitted. QDCs were rejected when an eligible professional used an incorrect procedure code (i.e., HCPCS/CPT code).

MD/DO practitioners were more likely than other types of eligible professionals to participate in the eRx Incentive Program in 2010 (Table 24). About 1 in 5 (19.1%) MD/DOs participated while about 1 in 10 eligible professionals in the "other eligible professionals" category participated (10.2%).

Table 24. Number of Eligible Professionals who Participated in the eRx Incentive Program by Specialty Category (2010).

Type of Eligible Professional	Eligible Professionals	Eligible Professionals who Participated	% of Eligible Professionals who Participated
MD/DO	471,684	90,174	19.1%
Other Eligible Professionals	224,261	22,849	10.2%
Unknown/Missing	718	51	7.1%
Total	**696,663**	**113,074**	**16.2%**

Note for Table 24: Results included reporting via the claims, registry, and EHR options.

Certain specialties were more likely to participate in the 2010 eRx Incentive Program than others (Table 25). Family practice and internal medicine had the largest number of eligible and participating professionals, followed by cardiology, nurse practitioner, and ophthalmology. These specialties likely treat more patients where medications are prescribed. Appendix Table A32 presents results for all specialties. Specialties with particularly high rates of participation included cardiology and ophthalmology, as well as rheumatology, urology, and family practice.

Table 25. Specialties with the Largest Amount of Eligible Professionals who Participated in the eRx Incentive Program (2010).

Specialty	Eligible Professionals	Eligible Professionals who Participated	% of Eligible Professionals who Participated
Specialties with highest numbers	--	--	--
Family Practice	85,251	22,059	25.9%
Internal Medicine	80,389	18,916	23.5%
Cardiology	22,606	7,994	35.4%
Nurse Practitioner	43,423	7,523	17.3%
Ophthalmology	18,903	6,386	33.8%
Specialties with highest rates	--	--	--
Cardiology	22,606	7,994	35.4%
Ophthalmology	18,903	6,386	33.8%
Rheumatology	4,174	1,322	31.7%
Urology	8,924	2,642	29.6%
Family Practice	85,251	22,059	25.9%

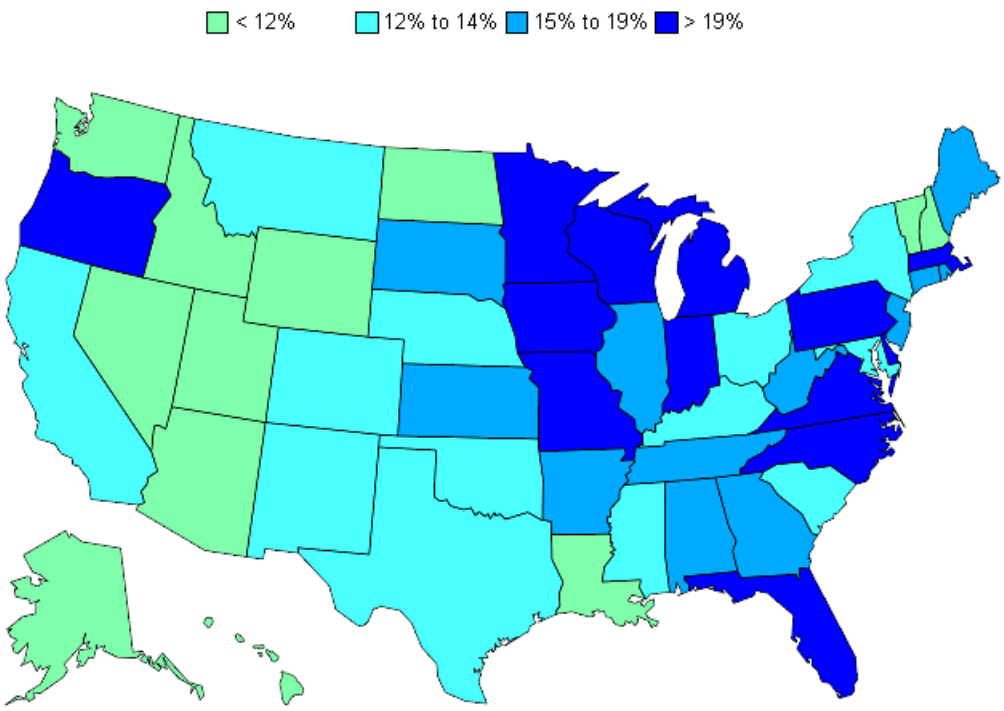
Note for Table 25: Results included reporting via the claims, registry, and EHR options.

Among eligible professionals in practices participating in the eRx Incentive Program through the GPRO (N=17,879), the most common eligible professional specialties were internists, family practitioners, physician assistants, nurse practitioners and radiologists (representing 15%, 9%, 7%, 6% and 5% of all eligible professionals encompassed within practices participating in the eRx Incentive Program through the GPRO, respectively) (no table).

There was a strong correlation between the number of Medicare beneficiaries seen by an eligible professional and the likelihood of participating in the 2010 eRx Incentive Program (Appendix Table A34). Eligible professionals with more than 200 beneficiaries with an eligible eRx instance were more than ten times more likely to participate than eligible professionals with fewer than 25 beneficiaries. This could indicate eligible professionals who would not meet the 10% incentive eligibility threshold were less likely to participate in the eRx Incentive Program.

Participation in the 2010 eRx Incentive Program varied by location. Figure 16 presents the distribution of participation rates across the country. The number of eligible professionals participating in the 2010 eRx Incentive Program ranged from 88 in North Dakota (5.0% of those eligible) to 8,015 in California (13.8% of those eligible) (Appendix Table A35). It should be noted that some state law limitations on electronic prescribing may affect eligible professionals' participation in the eRx Incentive Program.

Figure 16. Geographic Distribution of Eligible Professionals who Participated in the eRx Incentive Program (2010).



Note for Figure 16: Results included reporting via the claims, registry, and EHR options.

D. Incentive Eligibility

To qualify for an incentive payment of 2% of estimated Medicare Part B PFS allowed charges for covered professional services furnished by the eligible professional during the reporting period, an eligible professional or a GPRO participating in eRx as a group must be a successful eRx prescriber and their allowed charges for services in the eRx quality measure's denominator should be comprised of 10% or more of the eligible professional's total 2010 estimated Medicare Part B PFS allowed charges. In 2010, eligible professionals had to report the eRx quality measure for at least 25 eligible instances via one reporting option (i.e., claims, registry or EHR); instances could not be combined across multiple options. Practices participating through the GPRO in the eRx Incentive Program had to report on 2,500 eligible instances.

In 2010, 67,058 eligible professionals were successful electronic prescribers. Of those eligible professionals, 1,201 failed to meet the 10% threshold for incentive eligibility (Appendix Table A36). There were several specialties where many eligible professionals did not meet the threshold for incentive eligibility. These specialties may provide relatively few of the procedures available for the eRx measure (e.g., evaluation and management visits) and therefore could not reach the 10% threshold for incentive eligibility. Among eligible professionals with an MD/DO, the specialties with the highest number of successful prescribers who did not reach the 10% threshold included cardiologists, nephrologists, family practitioners and dermatologists (Appendix Table A36). Among other eligible professionals, nurse practitioners and physician assistants had the highest number of successful reporters who did not meet the 10% threshold.

Overall 65,857 eligible professionals qualified for an eRx incentive. This was 58.2% of those who participated (Appendix Table A33). Among specialties with at least 50 eligible professionals who participated, the rate of incentive eligibility ranged from less than 20% for seven specialties to over 60% for 11 specialties.

Table 26 presents the specialties with the highest number of eligible professionals earning an eRx incentive in 2010, as well as the specialties with the highest rates of incentive eligibility among those submitting data on the eRx quality measure. Internal medicine and family practice were among the specialties with the largest number of participants who were incentive eligible and who had the highest rates of incentive eligibility.

Table 26. Specialties with the Largest Amount of Eligible Professionals who Qualified for an Incentive for the eRx Incentive Program (2010).

Specialty	Eligible Professionals who Participated	Eligible Professionals who Qualified for an Incentive	% who Qualified for an Incentive
Specialties with highest numbers	--	--	--
Family Practice	22,059	15,656	71.0%
Internal Medicine	18,916	13,793	72.9%
Cardiology	7,994	5,331	66.7%
Ophthalmology	6,386	4,026	63.0%
Nurse Practitioner	7,523	3,060	40.7%
Specialties with highest rates	--	--	--
Rheumatology	1,322	969	73.3%
Internal Medicine	18,916	13,793	72.9%
Family Practice	22,059	15,656	71.0%
Geriatrics	690	477	69.1%
Urology	2,642	1,786	67.6%

Note for Table 26: Results included the claims, registry and EHR reporting options. Groups with low counts (i.e., chiropractors and nurse anesthetists) were not included in this table.

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 Medicare Part B PFS 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. TIN-level feedback reports are also available for every group practice that participated and include the individual NPI-level data. NPI-level feedback reports are also available for an individual eligible professional (as identified by his or her NPI) who participated in the Physician Quality Reporting System or the eRx Incentive Program.

B. Accessing Feedback Reports

Feedback reports can be accessed through two different primary processes. TIN-level feedback reports are available from the Physician and Other Health Care Professionals Quality Reporting Portal. NPI-level feedback reports are available to individual eligible professionals through the Part A and B Medicare Administrative Contractors (A/B MACs and carriers). Feedback reports for multiple program years are available via both of these processes. A third process was added in 2011 to allow NPI-level feedback report requests to be made through the Physician Quality Reporting System and eRx Incentive Program Communication Support Page.[24]

TIN-Level Feedback Report Access

2010 TIN-level feedback reports are accessible to practice—also referred to as TIN–representatives (i.e., not individual eligible professionals); practices have discretion whether to distribute among individual eligible professionals.

2010 TIN-level feedback reports are available through the Physician and Other Health Care Professionals Quality Reporting Portal. To access these reports, the TIN representative must create an Individuals Authorized Access to the CMS Computer Services (IACS) account, which is required 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.

[24] www.qualitynet.org/portal/server.pt/community/communications_support_system/234

NPI-Level Feedback Report Access

2010 NPI-level feedback reports are accessible to individual eligible professionals. Individual eligible professionals need to contact their A/B MAC or carrier to request the NPI-level feedback report, which will be e-mailed. They can also access their NPI-level feedback report through the Communication Support Page. For further information regarding this process, see the Educational Resources page of the Physician Quality Reporting System website.

In addition, in 2011 the Quality Reporting Communication Support Page was made available through which individual eligible professionals can request 2008-2011 NPI-level feedback reports. The Quality Reporting Communication Support Page is available through the Physician and Other Health Care Professionals Quality Reporting Portal, and does not require an IACS account.

C. Report Content

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

The 2010 Physician Quality Reporting System feedback reports are packaged at the TIN-level, with individual-level reporting (or NPI-level) and performance information for each eligible professional who reported under that TIN for services furnished during the reporting period. Reports include 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 include information on the measure applicability validation (MAV) process and any impact it had on the eligible professional's incentive eligibility. Physician Quality Reporting System and eRx Incentive Program participants 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, 2010 – December 31, 2010 (for the 12-month reporting period) and for services from July 1, 2010 – December 31, 2010 (for the 6-month reporting period) were analyzed to determine whether the eligible professional or group practice qualified for an incentive according to the specific reporting criteria of each program.

VI. HELP DESK

A. Background

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

B. Three Support Desks

1. The External User Services Help Desk provided assistance with obtaining an IACS Security Login for access to the Physician Quality Reporting System Portal. IACS (Individuals Authorized Access to CMS Computer Systems) had two levels of accounts for the Physician Quality Reporting System: Individual Practitioner for eligible professionals who submitted claims and received reimbursement under a personal Social Security Number, and Organizations, for eligible professionals who submitted claims and received reimbursement under a Taxpayer Identification Number (TIN). The EUS Help Desk assisted with vetting the Organization's Security Official, who is the first person in the group to register for an account. EUS received and approved IRS documents from the Organization to verify the employment status of the person seeking Security Official status. Then an End User would register, and only that End User would have access to the Physician Quality Reporting System Portal to retrieve the Feedback Report. Once the initial accounts were setup, users need to add the Physician Quality Reporting System user role. Near the end of 2010, the IACS support for the Physician Quality Reporting System was merged with the QualityNet Help Desk, to address vetting for the Security Official role in Organizations, IACS account issues, the new Annual Recertification requirement, assistance in obtaining the data submission role, etc. Eligible professionals still need to contact the EUS Help Desk for issues related to Medicare Enrollment and the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).

2. The CMS A/B MAC and Carrier Provider Contact Centers provide normal Medicare enrollment and claims submission support. This now includes the responsibility of disbursing the Physician Quality Reporting System payments to eligible professionals who earned incentives, paid at the TIN level. They answer questions related to whether a payment was disbursed, understanding the Remittance Advice, or explaining any offsets or adjustments. In 2010, the A/B MAC and Carriers were also tasked with accepting requests for individual NPI-level feedback reports through the Alternative Feedback Report Request Process. This enabled individuals, whether solo practitioners, or those within an Organization, to request the NPI-level Report be sent to them via email instead of via the Physician Quality Reporting System Portal. This alternative was implemented in response to some difficulties eligible professionals were having obtaining their IACS login.

3. The QualityNet Help Desk consisted of one level of support initially, known as Tier I, which consisted of a team dedicated to issues related to the Physician Quality Reporting System team. This tier handled questions in the summer and fall of 2008 regarding 2007 program year payments and feedback reports, as well as questions regarding 2008 program year reporting. They were available to answer a range of questions on issues such as eligibility, measures, reporting options, portal login, feedback reports, registries, and payments. In the summer of 2009, a second tier was added, known as Inquiry Support, to address specific measure questions and assist CMS with escalated payment or report issues. This tier was able to provide a level of detailed data review to eligible professionals who did not qualify for an incentive and needed information in addition to their feedback report. The Inquiry Support tier also handles requests for claims level data for eligible professionals who did not earn an incentive. In 2010, a Tier II Inquiry Support team was implemented to focus on providing answers to measures questions and program inquiries for both individual measure reporting as well as measures groups reporting, so that eligible professionals could better understand their feedback reports and use that knowledge to be more successful in future years. The Inquiry Support team became the Tier III Inquiry support level to handle claims detail requests. 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 will still need to contact the EUS Help Desk for issues related to Medicare enrollment and the PECOS system.

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

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

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

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

3. QualityNet Help Desk for questions on IACS, Portal Login, payments, reports, etc:
   Phone: 866-288-8912
   TTY: 877-715-6222
   Email: Qnetsupport@sdps.org

VII. CONCLUSION

The Physician Quality Reporting System and the eRx Incentive Program have grown over time and were expanded in 2010 to promote participation and reporting success. For example, the Physician Quality Reporting System has more measures available on which to report as well as more reporting options (e.g., EHRs and GPRO). For the eRx Incentive Program, the reporting criteria changed from requiring 50% of eligible cases in 2009 to only 25 eligible cases in 2010. Ultimately, the growth in participation and success resulted in CMS paying 72% more in total combined incentive payments compared to 2009.

There were further changes in 2011 that could impact the reporting experiences in these programs.

- The satisfactory reporting requirement for submitting data on individual measures through the claims option was reduced from 80% to 50% of instances in the Physician Quality Reporting System.
- Twenty measures and one measures group were added in the Physician Quality Reporting System.
- Ten measures were added for EHR reporting in the Physician Quality Reporting System.
- The GPRO II reporting option was added for smaller groups under both programs.

The reporting requirements to avoid the 2012 eRx payment adjustment were implemented; these requirements are based on an eligible professional's 2011 reporting experience. In addition, the Affordable Care Act mandated a number of changes to the reporting programs that will shape future experience. There will be a reduction in the applicable incentive percentages from 2% to 1% for both programs in 2011. Furthermore, in future years these programs' payment adjustments are required for eligible professionals who do not satisfy reporting requirements in the Physician Quality Reporting System (starting in 2015) or the eRx Incentive Program (in years 2012, 2013 and 2014). The Affordable Care Act also authorized a 0.5% Physician Quality Reporting System incentive increase if eligible professionals satisfactorily report Physician Quality Reporting System measures for a year through a Maintenance of Certification Program and meet certain requirements for participating in a Maintenance of Certification program for a year and successfully submit a Maintenance of Certification program practice assessment. Overall, the Physician Quality Reporting System and the eRx Incentive Program have continuously expanded to ensure participation and reporting success to prepare for the eventual payment adjustments associated with these important programs and to move toward a value-based purchasing system.