

Why GAO Did This Study

Health care payers—including Medicare—are increasingly using VBP to reward the quality and efficiency instead of just the volume of care delivered. Both traditional and newer delivery models use this approach to incentivize providers to improve their performance. Feedback reports serve to inform providers of their results on various measures relative to established targets. The American Taxpayer Relief Act of 2012 mandated that GAO compare private entity and Medicare performance feedback reporting activities.

GAO examined (1) how and when private entities report performance data to physicians, and what information they report; and (2) how the timing and approach CMS uses to report performance data compare to that of private entities. GAO contacted nine entities—health insurers and statewide collaboratives—recognized for their performance reporting programs. Focusing on physician feedback, GAO obtained information regarding report recipients, data sources used, types of performance measures and benchmarks, frequency of reporting, and efforts to enhance the utility of performance reports. GAO obtained similar information from CMS about its Medicare feedback efforts.

What GAO Recommends

The Administrator of CMS should consider expanding performance benchmarks to include state or regional averages, and disseminating feedback reports more frequently than the current annual distribution.

View [GAO-14-279](#). For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

March 2014

MEDICARE

Certain Physician Feedback Reporting Practices of Private Entities Could Improve CMS's Efforts

What GAO Found

Private entities GAO reviewed for this study selected a range of measures and benchmarks to assess physician group performance, and provided feedback reports to physicians more than once a year. Private entities almost exclusively focused their feedback efforts on primary care physician groups participating in medical homes and accountable care organizations, which hold physicians responsible for the quality and cost of all services provided. They limited their feedback reporting to those with a sufficient number of enrollees to ensure the reliability of reported measures. The entities decided on the number and type of measures for their reports, and compared each group's performance to multiple benchmarks, including peer group averages or past performance. All the entities used quality measures, and some also used utilization or cost measures. Because of the variety of quality measures and benchmarks, feedback report content differed across the entities. Some entities noted that in addition to national benchmarks, they compared results to state or regional level rates to reflect local patterns of care which may be more relevant to their physicians. Most health insurers spent from 4 to 6 months to generate their performance reports, a period that allowed them to amass claims data as well as to make adjustments and perform checks on the measure calculations. Commonly, private entities issued interim feedback reports, covering a 1-year measurement period, on a rolling monthly, quarterly, or semiannual schedule. They told GAO that physicians valued frequent feedback in order to make changes that could result in better performance at the end of the measurement period.

Feedback from the Centers for Medicare & Medicaid Services (CMS) included quality measures determined by each medical group, along with comparison to only one benchmark, and CMS did not provide interim reports to physicians. The agency has phased in performance feedback in order to meet its mandate to apply value-based payment (VBP) to all physicians in Medicare by 2017, a challenge not faced by private entities. In September 2013, CMS made feedback reports available to 6,779 physician groups. While private entities in this study chose the measures for their reports, CMS tied the selection of specific quality measures to groups' chosen method of submitting performance data. Although both CMS and private entities focused their feedback on preventive care and management of specific diseases, CMS's reports contained more information on costs and outcomes than some entities. While private entities employed multiple benchmarks, the agency only compared each group's results to the national average rates of all physician groups that submitted data on any given measure. CMS's use of a single benchmark precludes physicians from viewing their performance in fuller context, such as relative to their peers in the same geographic areas. CMS's report generation process took 9 months to complete, several months longer than health insurers in the study, although it included more steps. In contrast to private entity reporting, CMS sent its feedback report to physicians once a year, a frequency that may limit physicians' opportunity to make improvements in advance of their annual payment adjustments.

The Department of Health and Human Services generally concurred with GAO's recommendations and asked for additional information pertaining to the potential value of using multiple benchmarks to assess Medicare physicians' performance.