

December 2012

MEDICARE  
PHYSICIAN  
PAYMENT

Private-Sector  
Initiatives Can Help  
Inform CMS Quality  
and Efficiency  
Incentive Efforts



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## Why GAO Did This Study

The Middle Class Tax Relief and Job Creation Act of 2012 required that GAO examine private-sector initiatives that base or adjust physician payment rates on quality and efficiency, and the initiatives' applicability to the Medicare program. This report provides information on (1) common themes among private entities with payment incentive initiatives, and physician perspectives on those themes; and (2) the extent to which CMS's financial incentive initiatives for Medicare physicians reflect such themes. GAO acquired information from nine private entities on 12 initiatives selected from expert referrals to include various sizes, types, and geographic locations. GAO also obtained information from physician groups, state medical societies, and national physician organizations. GAO additionally interviewed CMS officials and reviewed relevant CMS documents.

## What GAO Recommends

CMS should consider whether certain private-sector practices could broaden and strengthen the Value Modifier program's incentives. Specifically, the agency should consider rewarding physicians for performance improvement as well as for meeting absolute benchmarks, and making more timely payment adjustments to better reflect recent physician performance. Furthermore, the agency should develop a strategy to reliably measure the performance of solo or small physician practices. HHS concurred with all of GAO's recommendations for CMS.

View [GAO-13-160](#). For more information, contact James Cosgrove at (202) 512-7114 or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov).

# MEDICARE PHYSICIAN PAYMENT

## Private-Sector Initiatives Can Help Inform CMS Quality and Efficiency Incentive Efforts

## What GAO Found

GAO identified several common themes among private entities under review with initiatives that provide incentives for high-quality, efficient care, and selected physician organizations generally support these themes. Specifically:

- Private entities generally measure performance and make incentive payments at the physician-group level rather than at the individual-physician level. Physician organizations favor this approach.
- Private entities use nationally endorsed performance metrics and noted the need for a standardized set of metrics across all payers. Physician organizations concur that a standardized set of metrics would be less administratively complex.
- Most private entities in GAO's study provide financial incentives tied to meeting absolute benchmarks—fixed performance targets—or a combination of absolute benchmarks and performance improvement. Physician organizations prefer incentives tied to absolute benchmarks over those based on how physicians perform relative to their peers. Physician organizations also favored incentives that reward improvement because baseline levels of performance vary.
- While private entities' incentive payments vary in size and in method, private entities typically provide such payments within 7 months of the end of the performance measurement period. Physician organizations stated that financial incentives should be distributed soon after the measurement period to have the greatest effect on performance.

The efforts of the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers the Medicare program—to transform the physician payment system in Medicare reflect, to varying degrees, the themes that GAO identified among selected private entities with physician payment incentives. Specifically, CMS is taking steps to do the following:

- Focus on group-level performance measurement and payment adjustments in the Value-based Payment Modifier (Value Modifier) program, designed to adjust Medicare payments to physicians using performance data on the quality and cost of care provided. However, CMS has yet to develop a method of reliably measuring the performance of physicians in small practices in the Value Modifier program.
- Apply Value Modifier payment adjustments to outlier physicians—rewarding high performers and penalizing poor performers—using absolute performance targets but not performance improvement. Under this benchmarking strategy, it is likely that only high performers will elect to participate in the program's payment adjustment.
- Annually adjust payments through the Value Modifier 1 year after the performance measurement period ends, rather than applying the Value Modifier closer to the time of service delivery. This time lag between performance and payment adjustment may diminish the significance of the incentive to physicians.

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## Abbreviations

ACO	accountable care organization
AQC	Alternative Quality Contract
BCBS MA	Blue Cross Blue Shield of Massachusetts
BCBS MI	Blue Cross Blue Shield of Michigan
CAC	Collaborative Accountable Care
CA P4P	California Pay-for-Performance
CMS	Centers for Medicare & Medicaid Services
EHR	electronic health record
HHS	Department of Health and Human Services
IHA	Integrated Healthcare Association
IPA	Independent Practice Association
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
PCMH	patient-centered medical home
PGIP	Physician Group Incentive Program
PPACA	Patient Protection and Affordable Care Act
PQRS	Physician Quality Reporting System
SGR	sustainable growth rate
TIN	Tax Identification Number
Value Modifier	Value-based Payment Modifier

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**United States Government Accountability Office**  
Washington, DC 20548

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December 26, 2012

The Honorable Max Baucus  
Chairman  
The Honorable Orrin G. Hatch  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Fred Upton  
Chairman  
The Honorable Henry Waxman  
Ranking Member  
Committee on Energy and Commerce  
House of Representatives

The Honorable Dave Camp  
Chairman  
The Honorable Sander Levin  
Ranking Member  
Committee on Ways and Means  
House of Representatives

Medicare's ability to control spending remains a serious long-term financial challenge.<sup>1</sup> Physicians play a central role in the growth of Medicare expenditures both through the services they provide and the services they order, including hospital admissions, diagnostic tests, and referrals to other physicians. Evidence suggests that higher utilization of these services does not necessarily result in better health outcomes. As concerns about Medicare solvency have grown, so has interest in transforming Medicare's physician payment system to provide incentives for high-quality care delivered more efficiently.

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<sup>1</sup>Medicare is a federal health insurance program for people age 65 and older, individuals under age 65 with certain disabilities, and individuals diagnosed with end-stage renal disease. About three out of four beneficiaries are enrolled in Medicare's traditional fee-for-service program; the rest are enrolled in private health plans under the Medicare Advantage program.

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Physicians in traditional Medicare are paid under a national fee schedule—with an associated payment rate for each service rendered—in conjunction with a system of spending targets called the sustainable growth rate (SGR).<sup>2</sup> The Medicare physician fee schedule is updated annually by the SGR system, with the intent of limiting the total growth in Medicare spending for physician services over time. Because of rapid growth in Medicare spending for physician services, the SGR has called for fee reductions since 2002. However, congressional action has temporarily averted such fee reductions for 2003 through 2012.<sup>3</sup> Payments under the physician fee schedule totaled about \$67 billion in fiscal year 2011, accounting for about 12 percent of total Medicare spending.

Because physicians both directly and indirectly affect total health care spending, many private health care purchasers, such as insurers, have initiated programs to reward high-performing physicians and encourage patients to obtain care from these physicians, and these programs have evolved to reflect the increased sophistication of payers and providers. Since the late 1990s, some purchasers have provided financial incentives to physicians for meeting certain performance measures for quality and efficiency, an initiative known as pay-for-performance. As these efforts have evolved, some private purchasers have sought to improve quality and efficiency using models of coordinated care delivery that may incorporate elements of an accountable care organization (ACO)<sup>4</sup> or a patient-centered medical home (PCMH).<sup>5</sup>

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<sup>2</sup>The Balanced Budget Act of 1997 established the SGR formula system, replacing an earlier targeting system—the Medicare Volume Performance Standard—as a mechanism to determine updates to physician payments in fee-for-service Medicare. See Pub. L. No. 105-33, § 4503, 111 Stat. 251, 433 (codified at 42 U.S.C. § 1395w-4(f)).

<sup>3</sup>See 42 U.S.C. § 1395w-4(d).

<sup>4</sup>An ACO refers to a group of service providers that will work together to coordinate care for the patients they serve. ACOs create incentives for health care providers to work together to treat an individual patient across care settings—including physicians' offices, hospitals, and long-term care facilities. ACOs can potentially receive a portion of the net savings they achieve through reduced costs and improvements in quality of care.

<sup>5</sup>In a PCMH, a designated physician, often in primary care, is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging and coordinating care with other qualified professionals. Other principles of a PCMH include performance measurement, patient shared decision making, and enhanced patient access.

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In 2007, we reported on various ways that several health care purchasers profiled the performance of physicians in their networks to draw comparisons between efficient and inefficient providers, and linked their performance evaluation results to a range of financial incentives. We recommended that the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers the Medicare program—start a physician profiling system with a focus on efficiency to help control Medicare spending.<sup>6</sup> In 2008, the Medicare Improvements for Patients and Providers Act required HHS to implement a Physician Feedback Program that includes distribution of confidential feedback reports to physicians on the resources used to provide care to Medicare beneficiaries, with the option of including quality measures.<sup>7</sup> In 2011, we reported on CMS’s efforts and the challenges that the agency faced in developing the methodology and distributing physician feedback reports.<sup>8</sup> In 2010, the Patient Protection and Affordable Care Act (PPACA) directed HHS to establish a Value-based Payment Modifier (Value Modifier) program under which Medicare physician payments are to be adjusted for quality and efficiency of care.<sup>9</sup> HHS is required to phase in the Value Modifier beginning in 2015 and plans to do so using performance data derived from the Physician Feedback Program; it is required to cover all physicians under the Value Modifier program by 2017.<sup>10</sup> PPACA also established a number of coordinated care delivery models and gave CMS the authority to test others through its Innovation Center.<sup>11</sup>

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<sup>6</sup>GAO, *Medicare: Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency*, [GAO-07-307](#) (Washington, D.C.: Apr. 30, 2007).

<sup>7</sup>Pub. L. No. 110-275, § 131(c), 122 Stat. 2494, 2526 (2008) (codified at 42 U.S.C. § 1395w-4(n)).

<sup>8</sup>GAO, *Medicare Physician Feedback Program: CMS Faces Challenges with Methodology and Distribution of Physician Reports*, [GAO-11-720](#) (Washington, D.C.: Aug. 12, 2011).

<sup>9</sup>Pub. L. No. 111-148, § 3007, 124 Stat. 119, 373 (2010) (codified at 42 U.S.C. § 1395w-4(p)).

<sup>10</sup>On or after January 1, 2017, HHS may apply the Value Modifier to additional eligible professionals, such as physical therapists and qualified speech-language pathologists.

<sup>11</sup>The CMS Innovation Center tests and evaluates payment and service delivery models for beneficiaries of CMS healthcare programs, with the goal of spreading successful solutions across the country.

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The Middle Class Tax Relief and Job Creation Act of 2012 required that GAO examine private-sector initiatives that base or adjust physician payment rates on quality and efficiency and assess their applicability to the Medicare program.<sup>12</sup> To meet this requirement, this report provides information on (1) common themes among private entities with initiatives that offer payment incentives for high-quality, efficient physician care, as well as physician perspectives on those themes; and (2) the extent to which CMS's financial incentive initiatives for Medicare physicians reflect such themes.

To identify common themes among private entities with payment incentives for high-quality, efficient physician care, we obtained information from nine private entities that conduct 12 prominent initiatives. (See table 1.) To identify such entities, we interviewed academic and industry experts on physician performance measurement and payment reform. We also reviewed health care policy research literature and a transcript from CMS's National Provider Call organized to provide input on best practices from pay-for-performance in the private sector. The private entities identified from these sources vary by geography, size, and type, and have initiatives that include pay-for-performance, PCMH, and ACO models. The initiatives referenced in this report are sponsored by two national health plans, three Blue Cross Blue Shield plans, one multistate plan, two substate plans, and one multistakeholder association, comprised of health plans, physician groups, and hospital systems, among others. The themes that we discuss in this report reflect the initiatives of the nine entities we studied and may not be generalizable to all private entities that provide financial incentives to physicians for quality and efficiency. Also, we did not conduct independent analyses of the effectiveness of the incentive initiatives.

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<sup>12</sup>See Pub. L. No. 112-96, § 3003(b)(2), 126 Stat. 156, 187 (2012).



**Table 1: Private Entities and Physician Payment Initiatives in Our Study**

Private entities	Incentive initiatives	Locations
CareFirst BlueCross BlueShield	<u>Patient-Centered Medical Home (PCMH)</u> : The health plan rewards primary care physicians for participating in provider panels; controlling overall cost and quality of care; and maintaining care plans for high-cost, high-risk patients.	District of Columbia, Maryland, and Virginia
Blue Cross Blue Shield of Massachusetts	<u>Alternative Quality Contract (AQC)</u> : The health plan negotiates 5-year contracts with physician organizations that are based on a global budget covering all care for the patient population. Physician organizations share risk in that they are accountable for a share of any budget overspending but receive a share of any budget underspending. The plan makes incentive payments to physician organizations demonstrating high performance on quality and outcome metrics.	Massachusetts
Blue Cross Blue Shield of Michigan	<u>Physician Group Incentive Program (PGIP)</u> : The health plan rewards physician organizations and their participating physician practices for their performance on quality, efficiency, and practice transformation. Physician organizations can choose to participate in a variety of incentive options, ranging from process and information-system transformation initiatives to condition-focused initiatives.	Michigan
Cigna	<u>Collaborative Accountable Care (CAC)</u> : The health plan rewards physician groups for performance on quality, affordability, and patient experience. The plan adjusts payments up or down on the basis of the group's total medical cost trend.	Arizona, California, Colorado, Connecticut, Georgia, Maine, Missouri, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Tennessee, Texas, Vermont, and Virginia
Dean Clinic and Dean Health Plan	<u>Pay-for-Performance Incentive Program (Dean Clinic)</u> : The organization ties a certain amount of payment to performance; physicians can choose from a variety of incentive options within five performance areas, such as patient satisfaction. <u>Primary Care Redesign (Dean Clinic)</u> : The organization ties a certain portion of payment to primary care practices to performance on quality and efficiency metrics, offering the potential to earn money beyond normal market pay. <u>Practitioner Incentive Model (Dean Health Plan)</u> : The health plan rewards network primary care groups with bonuses on the basis of performance on quality, member satisfaction, and efficiency metrics.	Wisconsin
HealthPartners	<u>Partners in Excellence</u> : The health plan rewards physician groups with performance bonuses on the basis of quality, affordability, and patient experience. <u>Partners in Progress</u> : The health plan ties a portion of physician groups' pay to quality, patient experience, and efficiency performance, the details of which are negotiated with the physician groups.	Iowa, Minnesota, North Dakota, South Dakota, and Wisconsin
Integrated Healthcare Association	<u>California Pay-for-Performance (CA P4P)</u> : This statewide, multistakeholder organization facilitates performance-based physician payment through the use of a common set of quality and efficiency metrics. Quality performance results are publicly reported.	California

Rocky Mountain Health Plans	<u>Incentive Program</u> : The health plan negotiates incentive contracts with physicians that tie a certain portion of payment to their performance on quality metrics and efficiency.	Colorado
UnitedHealth Group	<u>Performance-based contracting</u> : The plan negotiates contracts with physicians or medical groups, or both, to determine the amount that the physicians' fees would be increased for superior quality and efficiency performance, as well as the specific quality and efficiency metrics used.	Nationwide

Source: GAO.

To obtain physicians' perspectives on the common themes that we identified, we interviewed physician groups associated with particular initiatives and other organizations representing physicians with knowledge of the initiatives.<sup>13</sup> The physician groups varied in size—with as many as 1,600 physicians—and structure. We spoke with physician leaders of two independent practice associations, a large primary care group practice, medical staff at a hospital, and an alliance of medical groups. We also spoke with representatives of three state medical societies and a state professional association representing physician organizations. Additionally, we reviewed comment letters submitted by national physician organizations, including the American College of Cardiology and the American Medical Association, in response to CMS's proposed rule regarding Medicare incentive payments for quality and efficiency.<sup>14</sup> The perspectives that we discuss in this report reflect those physicians groups or organizations whose comments we sought or reviewed and may not be generalizable to all physicians.

To examine the extent to which CMS's financial incentive initiatives for Medicare physicians reflect the common themes among private entities that we identified, we reviewed the agency's 2013 revisions to payment policies under the Medicare physician fee schedule final rule, which addressed implementation of the physician Value Modifier and finalized

<sup>13</sup>We use the term "physician groups" to describe organizations where physicians have a shared stake in performance measurement and incentive payment. In this report, physician groups can include formally established medical groups, hospital divisions, virtual or informal physician groups, or independent practice associations.

<sup>14</sup>Proposed Rule, Revisions to Payment Policies Under the Physician Fee Schedule, DME Face to Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013, 77 Fed. Reg. 44,722 (July 30, 2012).

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CMS's overall approach.<sup>15</sup> We also conducted interviews with agency officials and examined relevant CMS documents.

We conducted this performance audit from April to December 2012 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

Because Medicare pays for a large share of health care throughout the country, its size and market power can help it to lead payment reforms in the rest of the health care system. Its use of financial incentives for reaching performance targets can, in effect, set standards that private payers may adopt. However, statutory requirements for the Medicare program limit the types of changes that CMS can implement. For example, Medicare must pay for health care delivered by any eligible physician willing to accept Medicare payment and follow Medicare requirements, and must pay uniform Medicare rates to all physicians. Therefore, unlike private health care purchasers, CMS cannot exclude poor-performing providers from participating in the program and cannot negotiate different reimbursement rates with different providers.

In recent years, in response to legislation, HHS has taken steps to transition Medicare physicians from a fee-for-service system in which only the volume of services is rewarded, to one in which value—as measured by the quality and the efficiency with which that care is delivered—also determines payment. CMS has worked with physician groups in designing and implementing the following physician initiatives, among others.

- Physician Quality Reporting System (PQRS). PQRS collects physician-reported data on quality measures for covered services furnished to beneficiaries. CMS provides an incentive payment to physicians who satisfactorily report quality data. The agency

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<sup>15</sup>Final Rule with Comment Period, Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013, 77 Fed. Reg. 68,892 (Nov. 16, 2012).

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announced that, in 2013, physicians who do not satisfactorily meet PQRS submission requirements will have their fee schedule amount reduced by 1.5 percent for services furnished in 2015.<sup>16</sup>

- Value Modifier Program. PPACA directed HHS to establish a Value Modifier to adjust Medicare payments to some physicians in 2015 and to all physicians in 2017 on the basis of the quality and cost of care provided.<sup>17</sup> To develop the Value Modifier, CMS plans to use performance information on quality and cost metrics derived from Medicare claims and data submitted under PQRS.<sup>18</sup> Because the Value Modifier program must be budget neutral, upward adjustments will depend on the total sum of negative adjustments in a given year.
- Shared Savings Program. CMS has finalized rules under which physicians, hospitals, and other health care providers may work together to better coordinate care for Medicare beneficiaries through an ACO.<sup>19</sup> While individual physicians continue to be paid under the Medicare fee schedule, the agency plans to develop a benchmark for each ACO against which its performance is measured to assess whether it qualifies to receive shared savings or in some cases be held accountable for losses.<sup>20</sup>

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<sup>16</sup>See 42 U.S.C. § 1395w-4(m).

<sup>17</sup>See 42 U.S.C. § 1395w-4(p). In addition, to ensure that the Value Modifier encourages physicians to care for beneficiaries with complicated cases, there will be an additional upward payment adjustment for groups of physicians furnishing services to high-risk beneficiaries.

<sup>18</sup>Performance results will be distributed to physicians by means of CMS's Physician Feedback Program. PPACA requires HHS to coordinate the Value Modifier with the Physician Feedback Program. CMS plans to distribute at least one feedback report to physicians before paying them differentially on the basis of their performance. In addition to this feedback report, in 2012 CMS began distributing simplified interim feedback reports that are processed about 1 month after the reporting period.

<sup>19</sup>See Pub. L. No. 111-148, §§ 3022, 10307, 124 Stat. 119, 395, 940 (2010) (codified at 42 U.S.C. § 1395jjj); 76 Fed. Reg. 67,802 (Nov. 2, 2011).

<sup>20</sup>In order to participate, ACOs in the Shared Savings Program must meet all eligibility and program requirements, including serving at least 5,000 Medicare fee-for-service beneficiaries and participating for at least 3 years. CMS implemented both a one-sided shared savings model that poses no risk to ACOs for losses and a two-sided model that requires ACOs to share both savings and losses, allowing the ACO to choose for its first agreement period.

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- Comprehensive Primary Care Initiative and Multi-Payer Advanced Primary Care Practice. Eligible primary care practices may receive shared savings rewards under some of CMS's demonstrations related to operating a PCMH. Under the Comprehensive Primary Care Initiative, CMS intends to pay 500 primary care practices in seven markets for improved and comprehensive care management, and after 2 years offer them the chance to share in any savings they generate. For the Multi-Payer Advanced Primary Care Practice demonstration, CMS intends to award payment incentives through existing PCMH initiatives that are currently being conducted by states to make medical home practices more broadly available.<sup>21</sup>
  - Physician Compare Website. This Internet tool serves as a directory for beneficiaries, allowing them to search for a physician by specialty, location, hospital affiliation, and other factors. The profile pages also indicate if a physician satisfactorily participated in the PQRS. PPACA requires that CMS make quality and patient experience measures publicly available on the website by January 1, 2013.<sup>22</sup> Publishing comparable performance results can encourage physicians to improve their performance in order to attract more beneficiaries.

These legislated changes, along with market forces, have potential implications for the way many physicians practice. For example, emerging delivery models such as ACOs may lead physicians to join larger groups, more closely align with hospitals, and take on financial risk for managing patient care. Although many physicians who serve Medicare beneficiaries work in small practices, more are increasingly employed by hospitals and health care systems. As of 2008, nearly one-third of U.S. physicians worked in solo or 2-physician practices, 15 percent worked in groups of 3 to 5 physicians, 19 percent worked in practices of 6 to 50 physicians, and 13 percent practiced in hospital settings.<sup>23</sup> However, a 2011 study found

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<sup>21</sup>Each state will determine the additional amount it pays participating practices for transforming into medical homes and for providing services that are not otherwise covered under the traditional Medicare fee-for-service program. The form of the payment may include a monthly fee for each participating beneficiary attributed to a participating practice, pay-for-performance incentives, shared savings, or some combination of the above.

<sup>22</sup>See Pub. L. No. 111-148, § 10331, 124 Stat. 119, 966 (2010).

<sup>23</sup>Center for Studying Health System Change, *A Snapshot of U.S. Physicians: Key Findings from the 2008 Health Tracking Physician Survey* (September 2009), accessed October 3, 2012, <http://www.hschange.com/CONTENT/1078/>.

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that physicians are increasingly selling their practices or seeking employment directly with healthcare systems, and hospitals are aggressively acquiring physician practices to remain competitive.<sup>24</sup>

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**Common Themes among Private Entities Pertain to Performance Measurement and Incentive Payment; Physician Organizations Largely Concur with These Themes**

We identified several common themes among private entities with physician payment initiatives in our study. These included the importance of focusing on physician groups rather than individual physicians, the desire for a standardized performance measurement set, the use of absolute performance and improvement targets, the timely distribution of incentive payments, an emphasis on care coordination to improve quality and efficiency, and the use of other strategies to improve quality and efficiency. For the most part, physician organizations familiar with these themes expressed their support.

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**Stakeholders Largely Agreed That Performance Measurement and Incentive Payment Should Be at the Physician-Group Level**

**Private Entities**

Private entities in our study generally based incentive payments on the performance of physician groups rather than individual physicians largely because of methodological issues and the importance of reinforcing group-wide accountability. Most of the private entities we spoke with pointed out that individual-level measurement often does not generate sufficient performance data to produce credible results. For instance, for a condition-specific performance metric, a physician may see too few

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<sup>24</sup>Accenture, *Clinical Transformation: Dramatic Changes as Physician Employment Grows* (March 2011), accessed September 28, 2012, <http://www.accenture.com/us-en/Pages/insight-clinical-transformation-physician-employment-grows.aspx>.

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patients with the relevant condition to be measured reliably.<sup>25</sup> Integrated Healthcare Association (IHA) noted that using physician organizations as the unit of analysis in the California Pay-for-Performance (CA P4P) program helps to overcome small sample sizes that impede valid measurement of efficiency at the individual physician level, although sometimes even sample sizes at the physician organization level may not be adequate.<sup>26</sup> A representative at Blue Cross Blue Shield of Michigan (BCBS MI) stated that this methodological issue is especially relevant when measuring performance in specialty care practices.<sup>27</sup> Because subspecialists may provide distinct services within their specialties, they can look like outliers when compared with their specialty peers at the individual level. Several private entities told us that group-level measurement also promotes group-wide accountability. For example, representatives at Dean Clinic said that measuring performance at the group level allows each of its clinical divisions to leverage each physician's strengths, and keeps them engaged in performance improvement. In addition, BCBS MI believes that group-level measurement and payment may prevent physicians with particularly complex patients from being resistant to participating in the initiative.

Because many primary care physicians work in small, independent practices, CareFirst BlueCross BlueShield (CareFirst) PCMH program has developed a strategy for including them in its initiative. CareFirst physicians do not need to be a part of a formal medical group to participate in the program. Rather, they may organize voluntary, "virtual" panels for the purpose of performance measurement and incentive payments. Established physician groups may also participate, provided that they form subgroups of between 5 and 15 physicians—the panel size requirement for participation. As an incentive to join the program, CareFirst increases the fees paid under its physician fee schedule by 12 percentage points. It offers additional financial incentives to physician

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<sup>25</sup>Research has shown that reliable quality metrics can require a patient pool of up to 411. See: J. Cromwell et al., *Pay for Performance in Health Care: Methods and Approaches*, RTI Press publication no. BK-0002-1103 (Research Triangle Park, N.C.: RTI Press, 2011), retrieved March 14, 2012 from <http://www.rti.org/rtipress>.

<sup>26</sup>J. C. Robinson, T. Williams, and D. Yanagihara, "Measurement of and Reward for Efficiency in California's Pay-For-Performance Program," *Health Affairs*, vol. 28, no.5 (2009): 1438-1447.

<sup>27</sup>We define specialty care as health services in a specific field of medicine, such as cardiology, dermatology, and psychiatry.

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panels for bringing care costs within a budget target and for improving quality on a variety of metrics. CareFirst representatives believe that the primary care physician is in the best position to comprehensively understand a patient's needs—in particular, the needs of chronically ill patients—but that no one physician has a large enough patient pool for reliable performance measurement. They said that not only does panel formation allow for reliable performance measurement, but it also provides a structure for peer pressure given that all physicians in a panel have an economic stake in high performance.

Many of the private entities we spoke with were also consistent in their view that it is the responsibility of physician group management to drive individual physician performance improvement. Therefore, they not only provide physician groups with feedback reports at the group level, but most also provide supporting data at the individual physician level that can be used to generate individualized physician feedback reports. For example, under the Alternative Quality Contract (AQC), Blue Cross Blue Shield of Massachusetts (BCBS MA) sends performance data and reports in electronic format to each physician group's central leadership, who are responsible for sharing the results with individual physicians.<sup>28</sup> Similarly, under the Physician Group Incentive Program (PGIP), BCBS MI expects physician organizations to create appropriate reports at the practice unit and individual physician level to identify areas for improvement, as well as to track performance over time and guide focused system-transformation and performance improvement interventions. Some entities noted that peer pressure and competition within an organization can provide an incentive for physicians to improve their relative performance. For example, Rocky Mountain Health Plans shares relative performance data on resource use with certain physicians to facilitate communication about clinical quality and cost. Also, Dean Clinic representatives mentioned that reporting performance at the individual level within each specialty division instills peer pressure, which can help facilitate the improvement process.

Furthermore, many private entities we spoke with said that physician groups have complete discretion over how their incentive payments are used and therefore may not distribute their entire incentive payments to frontline physicians. For example, BCBS MI reported that, in general,

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<sup>28</sup>BCBS MA also meets regularly with the leadership of each AQC group to discuss the data and reports, and consults on priority improvements and best practices for achieving performance goals.



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physician groups distribute roughly one quarter of PGIP incentive payments directly to front-line physicians, and invest the remainder in systems improvements that benefit the practices and the physician group. Several other private entities also stated that physician group managers use their incentive payments for shared practice improvements, such as investing in new or additional information-technology capabilities, hiring case managers, and rewarding nonphysician staff. A BCBS MA representative noted that physician groups undertake these types of shared practice investments to help make the improvements in care quality and efficiency called for in the AQC.

## Physicians

Physician organizations in our review agreed that measurement at the physician group level for incentive pay is statistically more accurate than measurement at the individual physician level. They noted that one physician is unlikely to have a patient population large enough for statistical reliability, making it difficult for private entities to validate individual physician-level data. They also said that attributing patients to one physician for measurement purposes is difficult because physicians often work as a team to provide care. On the other hand, they noted that physician groups are likely to have the patient sample sizes needed to ensure accurate calculations and minimize the attribution problem. According to a letter to CMS from the American College of Cardiology, the physician group level provides sufficient data to ensure statistical significance but is still a level at which individual physician actions can improve quality.

Physician organizations in our study also agreed that it is their responsibility to drive individual physician performance improvement. They noted that when private entities provide information on individual physician performance, managers can develop tailored physician feedback reports using their own analytical tools. For example, physician groups can use the performance reports they receive internally to aggregate data across their entire patient population. They told us that these reports can be helpful because physicians are inclined to trust the data provided by their groups' managers, react to internal peer pressure, and want to examine their entire patient population.

In addition, physician organizations we contacted cited different approaches for distributing financial incentives. For example, Mesa County Physicians Independent Practice Association (IPA), Inc., receives incentive payments on a quarterly basis from Rocky Mountain Health Plans. It then pays its physician practices, each of which may decide to distribute the incentive payments in a different manner. Some physician

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practices in the IPA distribute the money equally to individual physicians; others distribute the money to individual physicians on the basis of their relative performance scores; and still others retain the money for capital improvement projects. A different approach is that used by ProHealth Physicians, Inc. (ProHealth), a 200-member physician group in Cigna's Collaborative Accountable Care (CAC) initiative. ProHealth reported setting aside a portion of the incentive payments to cover personnel and overhead costs associated with administering the initiative. About half of the remainder is distributed to individual physicians on the basis of their performance, with the highest performers receiving the most money and the lowest performers receiving no money. The rest of the incentive payment is considered profit and may be paid to its physician shareholders.

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## Private Entities Select from among Nationally Endorsed Metrics; Stakeholders Noted the Need for a Standard Set of Metrics across Payers

### Private Entities

In choosing performance metrics for their initiatives, the private entities we interviewed largely draw from those nationally endorsed by such groups as the National Quality Forum (NQF), which has endorsed over 700 metrics.<sup>29</sup> Many of the entities cited difficulties in developing sound quality metrics for their initiatives as the reason for selecting nationally endorsed metrics. However, some entities in our study supplement nationally endorsed quality-of-care metrics with others. For example, a representative of BCBS MA told us that, in collaboration with physicians, experimental measures can be used to provide evidence on the sample

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<sup>29</sup>NQF is a nonprofit organization with the lead responsibility for endorsing health care quality measures. HHS has contracted with NQF to perform various activities, including endorsement of quality and efficiency metrics for use in reporting on physician care. It also requested that NQF complete a report that prioritizes the 20 conditions identified by CMS that account for over 95 percent of Medicare's costs. See GAO, *Health Care Quality Measurement: The National Quality Forum Has Begun a 4-Year Contract with HHS*, [GAO-10-737](#) (Washington, D.C.: July 14, 2010); and *Health Care Quality Measurement: HHS Should Address Contractor Performance and Plan for Needed Measures*, [GAO-12-136](#) (Washington, D.C.: Jan. 13, 2012).

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size needed to generate reliable data for certain measures. Physician organizations participating in BCBS MA's AQC have the opportunity to work on the development of up to three experimental measures of their choosing each year on the basis of a list provided by the health plan. The rest of the AQC metrics are largely NQF-endorsed and are supported by entities such as CMS or the National Committee for Quality Assurance (NCQA).<sup>30</sup> To measure efficiency of care, many entities reported using a risk-adjusted total cost of care metric that captures all services provided to physicians' entire patient population.<sup>31</sup> HealthPartners, for one, uses its own NQF-endorsed total cost of care and resource use metrics calculated on a per-member basis to help identify potential overuse and underuse of services. Some private entities measure efficiency through metrics that are more specific than total cost of care. For example, Dean Health Plan's Practitioner Incentive Model has efficiency metrics that include generic drug prescription patterns and emergency room visits per 1,000 members, a metric also used by CMS for Medicare beneficiaries.

While NQF fosters agreement on national standards for measuring health care performance, no national consensus exists on a single best set of quality metrics. Most private entities that we spoke with were in agreement that use of a standardized set of performance metrics across payers would be ideal. Standardization may include uniformity in the metric selected, the benchmark against which performance is assessed, and the relevant patient population.<sup>32</sup> As expressed by HealthPartners representatives, a standardized set of metrics would send strong and consistent messages to providers, and make it easier for physician groups to focus on defined areas for quality improvement. California's IHA accomplished this by arranging for its health plans and physicians to work

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<sup>30</sup>NCQA is a national nonprofit organization that develops health care quality and performance standards, and manages accreditation, certification, and recognition programs for health plans, medical groups, and individual physicians. CMS and more than 90 percent of U.S. health plans use NCQA's Healthcare Effectiveness Data and Information Set to measure performance on various dimensions of care.

<sup>31</sup>Risk adjustment of certain performance metrics is done to account for health status and other patient characteristics, with the goal of preventing adverse selection.

<sup>32</sup>Researchers have noted that physician payment incentives based on measured performance may cause physicians to focus their attention on the services or outcomes measured, potentially taking attention away from other services or outcomes. A standardized metric set that is sufficiently broad could help ameliorate this concern. See Lawrence P. Casalino et al., "Will Pay-For-Performance And Quality Reporting Affect Health Care Disparities?," *Health Affairs*, vol. 26, no. 3 (2007).

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together to develop a uniform but dynamic set of performance metrics for statewide use. IHA reported that, until then, California physicians found it challenging to focus on performance improvement when many health plans provided incentives based on different metric sets. As of 2011, the CA P4P metric set included 85 metrics related to clinical quality, patient experience, meaningful use of health information technology, and appropriate resource use.

Several of the private entities in our study commented on the dearth of reliable specialty care metrics. For example, a representative from UnitedHealth Group noted inconsistency in the number of quality metrics across specialties. Nevertheless, most private entities that we spoke with included specialists in their incentive initiatives despite their limited performance data. Dean Clinic representatives discussed how they created a list of specialty care metrics for their pay-for-performance program in collaboration with their physicians. Over the course of 1 year, they offered each care division the opportunity to develop relevant, specialty-specific metrics, a process described as resource-intensive. To be formally adopted, these metrics required consensus among physicians that the new metrics applied to the majority of specialists within that department, and they had to be measureable through billing or electronic health record data. For example, physicians in the cardiovascular surgery division are measured on the percent of cardiovascular surgeries performed without a blood transfusion. Dean representatives surmised that, if a similar process were undertaken at the national level—whereby CMS would ask each specialty society to agree on 5 to 10 clinically relevant measures—it could be a step towards developing a robust, standardized set of metrics for specialty care.<sup>33</sup>

## Physicians

Physician organizations in our review indicated that they generally prefer quality metrics that have been endorsed by national groups, but are open to the inclusion of experimental metrics. They stated that standardization across payers would reduce the administrative burden associated with tracking distinct requirements of multiple metric sets among various initiatives. For example, a physician leader at ProHealth reported that, among the 21 value-based payment initiatives in which ProHealth participates, private insurers vary not only by which metrics are selected

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<sup>33</sup>Quality metrics go through various stages, including development, endorsement, selection, and use, among others.

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but by how the metrics are used. Representatives of the Massachusetts Medical Society added that, as a result, physicians may become overwhelmed and may not spend time to distinguish differences between the components of each initiative. Physician organizations also noted that some experimental metrics used in private-entity initiatives can be useful for filling in clinical areas that lack strong nationally endorsed metrics, although others may lack a significant medical rationale or be difficult to measure.

Furthermore, physician organizations in our study noted the importance of using specialty-specific metrics to ensure that performance is accurately attributed to specialty care providers for the care they furnish. To develop relevant metrics for specialty care providers, the Mesa County Physicians IPA organizes a team of local physicians each year to create more metrics for specialty care on the basis of new clinical evidence, similar to a process done for primary care metrics. However, according to a letter to CMS from the American Medical Association, value-based payment initiatives do not currently include all medical specialties because the tools for distinguishing value across specialties are inadequate. National medical societies have taken action to meet the need for more specialty metrics. For example, according to letters to CMS from national physician organizations, the Community Oncology Alliance has identified 16 key metrics of quality and value in cancer care delivery, and the American Association of Orthopaedic Surgeons has identified metrics for total knee replacements.

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## Private Entities Largely Reward Physicians for Meeting Absolute Targets and Improving Performance, an Approach That Physicians Favor

### Private Entities

Most private entities in our study base financial incentives on absolute performance targets or a combination of absolute targets and on improvement over time. Absolute targets are fixed and known to their physician groups during the performance measurement period, offering greater certainty regarding the efforts required to become eligible for payment. As such, they serve as a guide for high performers to maintain their quality and efficiency standings. Some entities reward physicians on a set of graduated absolute targets, whereby higher performance within

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the set of targets receives a greater reward. For example, under the AQC, physician groups are rewarded on the basis of performance targets (or “gates”) between 1 and 5. On a measure of colorectal cancer screening for members aged 51 to 75 years, AQC physician groups achieving a screening rate of roughly 65 percent met the minimum (“gate 1”) level of good performance on that measure, while those who screened about 83 percent met the maximum (“gate 5”) level of performance on that measure. Aggregating “gate” scores across the roughly 5 dozen measures in the AQC contract determines the overall performance and quality incentive payment. The effectiveness of the absolute benchmarking approach in motivating providers depends on where the performance targets are set. If the target is set too high and perceived to be too difficult to reach, physicians may not respond to the incentive. If it is set too low, the entity will be making incentive payments for performance already being delivered and will not encourage improvement.

Several private entities in our study combine absolute performance targets and improvement over time in their benchmarking strategies. Benchmarking based on performance improvement provides an incentive for lower performers as well as higher performers, as it rewards the gains achieved since past performance. Under the CA P4P program, performance on each metric is typically assessed against absolute targets—set at the 75th and 95th percentiles for the program in the previous year—and on improvement—closing the gap between the group’s previous year performance score and the 95th percentile of the previous year’s target. IHA representatives told us that, as of 2012, six of the seven health plans in the CA P4P program have adopted this benchmarking methodology.

Some of the entities we spoke with reward high relative performance along with improvement. Using a relative benchmark approach, physicians do not know their numerical target at the start of the performance period because their benchmark is based on the future performance of their peers. None of the entities we spoke with based incentive payments exclusively on relative performance. For instance, physician groups in Cigna’s CAC initiative must perform at a rate equal to or above the market average for each quality metric, or they must show improvement in their rate.

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## Physicians

Physician organizations in our review preferred tying incentives to absolute performance or improvement rather than relative performance. Some organizations saw merit in rewarding physician groups for achieving high performance rates; others favored incentives based, at least in part, on improvement because not all physician groups are at the same starting point. Selected organizations cautioned against using relative benchmarks, asserting that without prior knowledge of the level of performance needed to earn incentive pay, physician groups might not be willing to participate in an incentive initiative. Regardless of which benchmarking approach is used, frontline physicians might not know all the details of the incentive initiatives they work under. According to representatives of the Massachusetts Medical Society, frontline physicians likely know the performance targets that the physician group's management sets but may not be aware of key details of payers' incentive structures, such as the thresholds for achieving a higher incentive payment under BCBS MA's AQC initiative.

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## While Private Entities Offered Varied Payment Sizes and Methods, Physicians Say Timeliness Can Enhance the Incentive

### Private Entities

The incentive payments under the initiatives we reviewed varied in their size and method, but were similar in their timing. The size of payment incentives reported to us ranged from around 2 percent to over 20 percent of annual pay, with most initiatives offering at least 5 percent of annual pay in incentives. Several private initiatives in our study provide an incentive of at least 10 percent of annual physician revenue. We found three general methods used to make incentive payments:

- Some initiatives' incentives allow physicians to earn a percentage add-on to a fee schedule. Physicians can only benefit from meeting quality and cost targets under this type of incentive; if they fail to meet those targets, physicians would still receive the full fee-for-service payment. Generally, in such cases, the payer is at risk for high costs, not the physicians. For example, on the basis of primary care physicians' overall cost and quality performance, CareFirst's PCMH program offers a potential increase of 20 to 60 percent in its fee schedule.

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- Other initiatives implement the incentive through a bonus, such as a per-member-per-month bonus payment, which also does not carry significant physician risk. Cigna's CAC provides high- and improved-quality performers with a periodic per-patient payment, adjusted by the physician group's effect on the trend of total medical cost. BCBS MI's PGIP has an incentive pool that provides for a bonus payment depending on performance on specific subinitiatives in which participating physician organizations choose to participate.<sup>34</sup>
  - Still other initiatives implement the incentive payment through a withhold—whereby a portion of the payment due to a physician is withheld until the status of their performance is determined at the end of the measurement period. The amount withheld is returned only to physicians who meet performance targets, putting some cost risk on the physicians. HealthPartners representatives told us that their Partners in Progress program applies a withhold from market-based payment that can range from 1 to 5 percent of revenue. Under Rocky Mountain Health Plans' incentive program, physician groups negotiate with the health plan to determine the amount withheld.

In addition to providing bonuses to physician organizations, BCBS MA's AQC provides incentives to physician organizations through global budgets.<sup>35</sup> Under a 5-year contract, each participating physician organization begins with a fixed budget that covers costs for all patient care on the basis of the population it serves; annual adjustments are made to manage the risk faced by the physician organization, such as adjustments to account for any changes in patient population health status. Physician organizations share any money with BCBS MA that is saved by spending less than the budgeted amount for the patient population, but they also share the risk when more money is spent than is budgeted. BCBS MA also rewards physician organizations with a per-member per-month bonus for high performance as compared with fixed targets on a set of quality metrics.

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<sup>34</sup>In addition to the incentive bonuses, BCBS MI increases office visit fees paid to primary care and specialty practices that implement PCMH capabilities and are high performers under PGIP. Fees to practices not transforming systems of care and improving performance have been kept constant since 2009, according to BCBS MI.

<sup>35</sup>Physician organizations must care for at least 5,000 BCBS MA members in health maintenance organization or point of service plans.



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## Physicians

The private entities in our study generally distributed incentive payments to physician group managers during the year immediately following the performance period.<sup>36</sup> Specifically, most private entities paid incentives within 7 months of the end of the performance period. For instance, BCBS MI distributes PGIP incentive payments to physician organizations 2 months after the end of the 6-month performance period. BCBS MA provides AQC groups interim incentive payments monthly, and these payments are reconciled during the year after the annual performance period ends to reflect actual performance.

According to the physician organizations in our review, the responsiveness of physicians to payer initiatives is often tied to the size, method and frequency of the incentive payment. Regarding the appropriate size of the incentives, physician organizations noted that the larger the potential payoff, the larger their performance improvement is likely to be. Although financial considerations are not the sole motivation for seeking high performance, physician organizations said they would like incentive payments to cover the costs of participating in the initiative—including the cost of data collection and the cost of improving performance.

Physician organizations in our review generally found the various types of incentive payments to be fair and useful from a management perspective. For instance, MedChi, the Maryland State Medical Society, reported that physicians are attracted to CareFirst's PCMH add-on to the fee schedule because it provides up-front capital that could be used to enhance productivity. In addition, according to a physician leader at ProHealth, the per-member per-month incentive payment under Cigna's CAC initiative helps with forecasting revenue and planning infrastructure improvements. Finally, representatives from the Mesa County Physicians IPA said that the withhold incentive structure established by Rocky Mountain Health Plans' Incentive Program works to keep physician groups attentive to performance improvement by knowing that some payment is at risk.

From the physicians' perspective, timely incentive payment cycles from private entities can be helpful for monitoring and adjusting performance. Physician organizations included in our review stated that incentive

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<sup>36</sup>Several private entities also noted that they give physicians an opportunity to dispute their performance scores or underlying data prior to the incentive payment.

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payments should be distributed soon after the achievement of performance to make the most difference. They noted in letters to CMS that, if an incentive is paid out very infrequently or if there is not a good understanding of how performance relates to incentive payment, it is unlikely to motivate improvement.

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## Private Entities Support Care Coordination with Additional Resources and Performance Metrics; Physicians Say Plan-Provided Data Help Coordinate Care

### Private Entities

A common element of most private entities with incentive initiatives is providing support to physicians for certain care-coordination activities.<sup>37</sup> We found that several private entities fund or partially offset the costs of ancillary providers—such as health coaches or nurse coordinators—who furnish care-management services to patients with certain health conditions. CareFirst’s PCMH, for one, hires local nurse coordinators and compensates physicians for preparing and monitoring care plans for certain patients. Physicians receive \$200 for each care plan created—working with CareFirst’s nurse coordinators to identify patients with multiple chronic diseases—and \$100 periodically to review and update those care plans. Private entities in our review that provide financial support for care management may increase physician office visit fees or make up-front payments to physicians for care coordination. As a key element of its CAC initiative, Cigna provides physician groups with an up-front care-coordination payment, which helps support nurse care coordinators charged with reaching out to and coordinating the care for patients who have been identified as at risk for hospital readmissions or who have gaps in care.

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<sup>37</sup>Care coordination is designed to reduce preventable hospitalizations arising from inadequate or inappropriate care, improve patient adherence to recommended medication and self-care regimens, and ensure communication among the many providers whom a patient sees. It is often used for patients with special health care needs or chronic health conditions.

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Some private entities we spoke with explicitly address care coordination in their performance measurement sets. For example, CA P4P uses a “care transitions” metric to assess whether physician groups have systems in place to follow up with a patient after laboratory tests and imaging services, as well as a care-coordination outcomes metric related to hospital readmissions. In addition, CareFirst’s nurse coordinators are responsible for monitoring physicians’ performance on metrics related to physician–patient engagement as a measure of physician groups’ ability to provide coordinated care. Many private entities reported that they provide physicians participating in their initiatives with information on gaps in care. UnitedHealth Group provides physicians with access to a web-based portal that uses claims data to identify gaps in care and opportunities for improvement. The portal identifies patients who may be due or overdue for preventive services or other health care services.

## Physicians

In addition to receiving financial support, physician organizations in our review approved of other efforts by private entities to advance care coordination. According to Massachusetts Medical Society representatives, physician groups have used data from insurers and other sources to target patients who would benefit most from care coordination. For example, a physician group reviews the data during weekly meetings where a clinical team discusses each physician’s list of patients and determines whether patient follow-up is needed. Similarly, ProHealth case managers use data from Cigna to schedule follow-up appointments, focus on care transitions, and serve as liaisons to Cigna’s nurse care coordinators. Selected organizations noted that such care coordination has the potential to both improve patient outcomes and moderate cost growth.

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## Some Private Entities Publicly Report Metrics and Use Tiered Networks, but Physician Organizations Generally Oppose These Mechanisms

### Private Entities

Several private entities in our study augment their payment initiatives with other strategies that offer physicians incentives to improve quality and efficiency:

- Some private entities report physician group performance results publicly. IHA publishes information on many CA P4P metrics on the state's Office of the Patient Advocate website. It cited a survey of physician organizations by a P4P program evaluator indicating that public reporting may motivate physician organizations to improve performance as much as, or more than, the financial incentives.<sup>38</sup>
- Some private entities use tiered physician networks as an incentive for patients to seek care from physicians deemed to be higher quality, more efficient, or both. Members who use physicians assigned to a high-quality, low-cost provider tier may receive a modest reduction in their coinsurance. A Cigna representative told us that tiered network options are available in all of its major markets. Individual physicians and physician groups can be designated as high quality and efficient on the basis of performance provided that they meet Cigna's required thresholds for patient sample size.
- UnitedHealth Group conducts a Premium Designation program to distinguish those physicians—and physician groups, by specialty—who deliver higher-quality and more-efficient care from other physicians or physician groups. UnitedHealth Group representatives noted that, although this program does not necessarily lead to lower cost sharing, it is designed to enhance transparency for plan members, which in turn may motivate physician performance. When a physician does not have a large enough sample size for reliable measurement, this is noted in the public designation displays.

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<sup>38</sup>Cheryl L. Damberg et al., "Taking Stock Of Pay-For-Performance: A Candid Assessment From The Front Lines," *Health Affairs*, vol. 28, no. 2 (2009): 517-525.

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Physicians

Physician organizations in our review noted that physicians generally oppose public reporting and network tiering but may respond positively to other nonpayment incentives. They cautioned against publicly reporting performance at the individual physician level because of data reliability and methodological concerns. In addition, according to representatives from the Massachusetts Medical Society, physicians in the state also are generally against network tiering in part because of concerns related to arbitrary thresholds based on relative performance and inaccurate information from claims data. However, selected organizations noted that using peer pressure within a physician group, reducing administrative burdens associated with participating in incentive initiatives, and improving the technological capabilities of physician groups could help increase the quality and efficiency of care.

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**CMS's Efforts to Tie Physician Payments to Quality and Efficiency Reflect, to Varying Degrees, Common Themes of Private Entities with Physician Payment Initiatives**

CMS's efforts—particularly through the Value Modifier program—to reform the Medicare physician payment system reflect, to varying degrees, the common themes we identified among private entities with physician payment initiatives. CMS is moving toward broader physician group-level performance measurement, but this level of measurement does not currently apply to small-practice physicians in the Value Modifier program. According to CMS, the agency is taking steps toward standardizing performance metrics across its programs and continues to solicit specialty care metrics. In its Value Modifier benchmarking strategy, CMS plans to tie physician incentives to absolute benchmarks, but not to performance improvement. It also plans to initially provide small downward fee adjustments to participating low performers and budget-neutral fee increases to participating high performers, but these adjustments will occur a year after the performance period ends. Additionally, CMS has recently taken action to promote greater care coordination and publicly report physician performance.

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## CMS Has Taken Steps to Expand Physician Group-Level Measurement, but Plans for Measuring Small Practices at This Level Remain Undeveloped in the Value Modifier Program

CMS has taken a number of steps toward broader physician group-level measurement for incentive payments. The agency recently announced it would modify its performance data collection by easing PQRS reporting requirements for physician groups. Because many physician practices report performance data as individual providers, CMS has sought to promote physician group-level reporting by making PQRS group-reporting requirements more flexible. In 2013, CMS intends to give physician groups the option of having CMS calculate quality metrics from claims data.<sup>39</sup> In addition to administrative claims-based reporting, CMS plans to offer alternative ways to meet group PQRS reporting standards, including through a web-based interface.

In addition, CMS intends to initiate the Value Modifier at the group level and has expanded the number of ACOs serving Medicare beneficiaries. Starting in 2015, CMS plans to apply the Value Modifier to claims submitted by physicians in groups with 100 or more eligible professionals that bill Medicare under a single Tax Identification Number (TIN). CMS stated that incentives paid under a physician group TIN not only allow for more reliable measurement than at the individual level, but elevate the importance of the group in which a physician practices—since each physician in the group receives the same payment modifier. In addition, CMS has increased the number of physicians who are eligible for incentive payments at the group level by adding to the number of ACOs under contract. After initially signing 65 ACOs as of April of 2012, CMS now contracts with 153 ACOs that serve more than 2.4 million beneficiaries, and the agency accepts new ACO applications annually.

Although these steps are designed to raise the number of physicians whose performance will be measured at the group level, CMS has not yet developed a method of reliable measurement for physicians in small practices in the Value Modifier program. Without such a method, the agency will likely measure those in small practices at the individual level in 2015, the performance year likely to determine the application of the

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<sup>39</sup>An Agency for Healthcare Research and Quality report noted that because administrative data, including claims data, are intended for financial management rather than quality assessment, they contain varying degrees of clinical detail and are often limited in content, completeness, timeliness, and accuracy. Patrick Romano, Peter Hussey, and Dominique Ritley, *Selecting Quality and Resource Use Measures: A Decision Guide for Community Quality Collaboratives*, Final Contract Report (prepared by the University of California and RAND Corporation, under contract No. 08003967), AHRQ Publication No. 09(10)-0073 (Rockville, Md.: AHRQ, May 2010).

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Value Modifier for all physicians in 2017. According to CMS, the decision not to initially apply the Value Modifier to established groups of less than 100 eligible professionals stemmed from concerns regarding untested cost metrics and administrative complexity. For instance, CMS reported that allowing physicians to be measured as an informally defined group would require the agency to establish and maintain additional group identifiers that would not as easily account for organizational changes. While CMS has reported that the agency intends to assess the possibility of allowing the aggregation or disaggregation of TINs in future years, it has not outlined a strategy to reliably measure the performance of the majority of physicians—those in small practices. According to CMS officials, among physicians that serve Medicare fee-for-service beneficiaries, more than two-thirds currently practice in groups of less than 25 individuals.

CMS officials stated that they do not plan to direct recipients on how to use incentive payments. Agency officials said there are no requirements for physician groups to use incentive payments for any particular purposes. In the case of ACOs, CMS asks applicants to identify how they plan to use payments to achieve the goals of the Shared Savings program—higher quality and lower cost—but it has not been prescriptive on how ACOs can use their shared savings.<sup>40</sup>

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### CMS Has Begun Standardizing Metrics and Seeking Ways to Better Measure Specialty Care

According to CMS officials, the agency is taking steps to both develop a standard set of metrics across its programs and enlarge the number of specialty care metrics in use. By 2014, the agency intends to further align the metrics in its Electronic Health Record (EHR) Incentive,<sup>41</sup> Shared Savings, and Value Modifier programs. By incorporating metrics that are endorsed by entities such as NQF, CMS's claims-based metrics may

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<sup>40</sup>ACOs reported to CMS that they plan to use potential shared savings for various purposes, including physician financial incentives, shareholder obligations, electronic medical record implementation, hiring care coordinators, and measuring performance for physician feedback.

<sup>41</sup>The EHR Incentive Programs, established by the American Recovery and Reinvestment Act of 2009, established programs under Medicare and Medicaid to provide incentive payments to eligible professionals and hospitals for the “meaningful use” of certified EHR technology. See GAO, *Electronic Health Records: First Year of CMS's Incentive Programs Shows Opportunities to Improve Processes to Verify Providers Met Requirements*, [GAO-12-481](#), (Washington, D.C.: Apr. 30, 2012).

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align with many private-sector programs as well.<sup>42</sup> CMS is also seeking ways to increase metrics for specialty care. For example, agency officials said that while they do not formally task specialty societies with developing measures specifically for PQRS, they annually solicit input on metrics from stakeholders, including medical specialty societies. Furthermore, CMS is considering allowing metrics that have been developed, collected, approved, and vetted by specialty societies to be reported on the Physician Compare website. The agency could potentially choose to include these specialty metrics in PQRS.

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### CMS to Target Outlier Performers and Use Absolute Benchmarks but Not Reward Improvement under Value Modifier Program

CMS plans to implement the Value Modifier by providing incentives only to physicians determined to be performance outliers on the basis of benchmarks using absolute targets based on existing performance, but not performance improvement. Beginning in 2013, physician groups with 100 or more eligible professionals that meet PQRS reporting standards can either elect to have their 2015 Medicare payment modified under a quality tiering approach or choose to effectively not have their payment modified at all.<sup>43</sup> For physician groups that select the quality tiering approach, only those with outlier scores in either quality or cost would be eligible for a payment adjustment; those in the highest tier would potentially see an increase in their payments under the fee schedule and those in the lowest tier would potentially see a reduction.<sup>44</sup> Physician group scores would be a composite derived from performance relative to the prior year national average for each applicable quality metric; cost

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<sup>42</sup>CMS officials noted that the agency does not seek to use solely NQF metrics, but can select from metrics that are not NQF-endorsed if certain areas of metrics do not exist in the body of NQF-endorsed metrics. In this case, CMS can use metrics from various entities, such as NCQA and specialty societies.

<sup>43</sup>To meet PQRS reporting standards, physician groups will need to a) self-nominate for the PQRS as a group for 2013 and report at least one measure, or b) elect the PQRS administrative claims option for 2013.

<sup>44</sup>In contrast, CMS's ACO quality benchmarks reward performance on the basis of a graduated level or sliding scale that starts at the 30th percentile.



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would be measured using current year comparisons.<sup>45</sup> Physician groups with low quality or high cost scores in a prior period will not be rewarded for either graduated levels of performance or improving their performance. CMS officials reported that the agency does not plan to consider rewarding performance improvement in the Value Modifier until more physicians participate in PQRS, and thus provide the agency with a more reliable understanding of how to set targets. However, until then, CMS's benchmarking strategy will make it less likely that many physicians will choose to put a portion of their payment at risk through the Value Modifier program. Because of current incentives, the quality tiering approach is likely to encourage participation only by those groups of physicians with high prior scores.

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**Value Modifier to Start Small with Fees Adjusted Annually, 1 Year after the Performance Period Ends, Rather Than More Frequently**

Agency officials reported that CMS plans to initially set the size of the Value Modifier fairly low. Medicare physicians participating in the quality-tiering approach of the Value Modifier program could potentially receive a downward adjustment of as much as 1 percent or an upward adjustment of up to two times a budget-neutral factor. (See table 2.) Because CMS's Value Modifier program must be budget neutral, upward adjustments are multiplied by a factor derived from the sum total of negative adjustments for both low performers and non-PQRS reporters. CMS officials told us they would like to receive performance data from the majority of physicians before considering any increase to the magnitude of the Value Modifier. The agency stated that it does not want to initially apply a greater downward payment adjustment for the low-quality/high-cost physician groups opting for the quality-tiering approach than that of nonsatisfactory PQRS reporters (1.5 percent in 2015).

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<sup>45</sup>CMS will produce a score for each measure that is expressed in standardized units that divide the difference between a physician group's performance rate and the benchmark by the metric's standard deviation. Each quality metric will be assigned to one of six domains (i.e., clinical care, patient experience, population/community health, patient safety, care coordination, and efficiency). For cost of care scores, CMS's total per capita cost metric will be its own domain, and its total per capita cost metrics for each of four chronic diseases will be in a separate domain. CMS will weight each measure's standardized score equally with other measures in the domain to obtain the domain standardized score. CMS will weight the domain scores equally to form the quality of care and cost composites scores.

**Table 2: CMS’s 2015 Value-Based Payment Modifier for Physician Groups That Choose the Quality-Tiering Approach**

Physician groups by quality performance	Physician groups by cost performance		
	Low cost performers	Medium cost performers	High cost performers
High quality performers	+2.0 multiplied by a budget-neutral factor <sup>a,b</sup>	+1.0 multiplied by a budget-neutral factor <sup>a,b</sup>	0.0%
Medium quality performers	+1.0 multiplied by a budget-neutral factor <sup>a,b</sup>	0.0%	-0.5%
Low quality performers	0.0%	-0.5%	-1.0%

Source: CMS.

<sup>a</sup>Because CMS’s Value-Based Payment Modifier program must be budget neutral, upward adjustments are multiplied by a factor derived from the sum total of negative adjustments for both low performers and nonreporters in the Physician Quality Reporting System (PQRS). To meet PQRS reporting standards, physician groups will need to a) self-nominate for the PQRS as a group for 2013 and report at least one measure, or b) elect the PQRS administrative claims option for 2013.

<sup>b</sup>Physician groups that meet PQRS reporting requirements and furnish services to high-risk beneficiaries, those with an overall average risk score in the top quartile, are eligible for an additional upward adjustment of 1.0 multiplied by a budget-neutral factor.

Moreover, to meet the budget-neutrality requirement for the Value Modifier, CMS decided to help fund participating high performers’ payment incentive by imposing an automatic downward adjustment of 1 percent for non-PQRS reporters.<sup>46</sup> Funds derived from downward adjustments for physicians with significantly poor performance or who do not meet performance reporting standards are CMS’s sole funds to increase the size of its performance incentive in the Value Modifier program.

Agency officials said that CMS expects to apply its Value Modifier annually 1 year after the performance period ends.<sup>47</sup> The agency has chosen to provide performance feedback reports 9 months after the end of the performance year, about 3 months before it would be applicable to the Value Modifier. For example, CMS would disseminate physician group feedback reports in the fall of 2014 that contain 2013 performance data to physician groups subject to the Value Modifier, and these reports will be the basis for the Value Modifier starting in 2015. According to

<sup>46</sup>Physician groups may avoid the 1.0 percent downward adjustment to their 2015 payment if they either (a) self-nominate for the PQRS as a group and report at least one measure or (b) elect that CMS compute metrics through the PQRS administrative claims option for 2013.

<sup>47</sup>CMS uses a 12-month performance period, which officials say gives the agency more reliable measures, sample sizes, and cost metrics.

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agency officials, the interval between the performance period and the initial feedback reports is needed to capture a lag in data submissions (up to 3 months after the end of the year), adjust claims for price standardization and risk, and conduct quality assurance testing. However, CMS may have a sufficient amount of reliable performance data with which to make more timely incentive payments in the Value Modifier program. The Research Data Assistance Center—a CMS contractor that provides technical support on Medicare claims processing—states that claims data are generally complete 6 months from the end of the calendar year. For example, over 96 percent of Medicare claims from 2011 were finalized by July of 2012.

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### CMS's Efforts Have Increasingly Focused on Promoting Care Coordination

CMS supports care-coordination incentives through several approaches. For 2013, CMS designated three additional care-coordination metrics in its administrative-based claims reporting for the group Value Modifier. For example, because care-coordination programs may reduce hospital readmissions,<sup>48</sup> CMS plans to measure the rate of hospital readmissions within 30 days after being discharged. In addition, to encourage patient follow-up postdischarge, CMS has developed a set of physician billing codes for services delivered within 30 days of discharge from a hospital or skilled nursing facility. Finally, CMS pays a monthly care-management fee to selected primary care practices under both its Comprehensive Primary Care Initiative and Multi-Payer Advanced Primary Care Practice Demonstration for purposes such as coordinating care for high-risk beneficiaries and helping to engage them in their care.

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### CMS Plans to Publicly Report Physician Groups' Performance Metrics on Its Physician Compare Website

In addition to regularly providing performance feedback to physicians, CMS intends to report physician performance scores to the public. As required by PPACA, CMS has implemented a plan for publicly reporting physician quality and patient experience metrics through the Physician Compare website. CMS developed Physician Compare to make information on quality of care widely available so that beneficiaries can make informed decisions in their choice of physician, and to encourage physicians to improve their quality of care. Agency officials said that CMS will begin publicly reporting statistically reliable performance results of

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<sup>48</sup>See *Report to the Congress: Medicare and the Health Care Delivery System*, (Washington, D.C.: Medicare Payment Advisory Commission, June 2012), 37.

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physician groups submitted through the PQRS Group Practice Reporting Option in 2013 or early 2014.

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## Conclusion

Many of the themes we identified among private entities implementing payment incentives are generally accepted by physician organizations in our study and are reflected—in whole or in part—in CMS’s efforts to implement the Value Modifier program. CMS has recognized the importance of group-level measurement, particularly through its initial application of the Value Modifier exclusively to physician groups. According to CMS officials, the agency has also begun to standardize its metrics across its programs while generally adhering to nationally accepted measures that are endorsed by entities such as NQF. Finally, CMS has taken steps to provide incentives for greater care coordination through both additional payments and performance metrics.

While CMS has taken steps toward addressing measurement of large physician groups, PPACA requires that the Value Modifier apply to all physicians—including those in solo and small practices—in 2017. To meet this requirement, CMS must address concerns regarding how best to reliably measure performance at that level. The challenge of measuring the performance of physicians in solo and small practices is more significant for CMS than for private entities because Medicare provides payment to any willing provider of care for beneficiaries. Yet, CMS has not laid out a strategy for its eventual application of the Value Modifier to solo and small-practice physicians in a manner that ensures measurement credibility. Options for doing so could include aggregation of solo and small practices into informal groups for measurement purposes.

Despite similarities to some themes found among private entities with physician payment initiatives, other themes are not fully reflected in CMS’s Value Modifier program. For instance, most of the private entities in our study provide incentives that are tied to absolute performance benchmarks or some combination of absolute benchmarks and improved performance; in addition to approving the use of absolute benchmarks, physicians in our review favored incentives that reward improvement because baseline levels of performance vary. Until CMS provides incentives for improvement, it is likely that few physician groups that are not already high performers will opt to participate in its quality-tiering approach.

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Additionally, because CMS's Value Modifier adjusts payments to physicians a year after the end of the performance period, the motivation to improve performance is diluted. While CMS has noted the need for 1 year to ensure accurate data, most of the private entities we contacted make incentive payments within 7 months of the end of the performance period so that physicians can readily see the financial effect of their performance. CMS's 1-year time lag between performance measurement and payment adjustment may diminish the significance of the incentive to physicians.

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## Recommendations for Executive Action

As CMS continues to implement and refine the Value Modifier program to enhance the quality and efficiency of physician care, the Administrator of CMS should consider whether certain private-sector practices could broaden and strengthen the program's incentives. Specifically, she should consider

- developing at least some performance benchmarks that reward physicians for improvement as well as for meeting absolute performance benchmarks, and
- making Value Modifier adjustments more timely in order to better reflect recent physician performance.

The Administrator should also develop a strategy to reliably measure the performance of solo and small physician practices, such as by aggregating their performance data to create informal practice groups.

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## Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment. In its written response, reproduced in appendix I, the department concurred with all three recommendations. Specifically, HHS stated that

- it will consider developing performance benchmarks that reward physician improvement once the agency has greater physician reporting on quality measures;
- as it develops the technology to handle claims data and quality data more rapidly, it will look for ways to decrease the gap between the performance period and the application of the Value Modifier; and
- it will seek to develop strategies to reliably measure the performance of solo and small physician practices.

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HHS also provided technical comments, which we incorporated as appropriate.

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We are sending copies of this report to the appropriate congressional committees and the Administrator of CMS. The report also is available at no charge on GAO's website at <http://www.gao.gov>.

If you or your staff have any questions regarding this report, please contact me at (202) 512-7114 or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

A handwritten signature in black ink, appearing to read 'James Cosgrove', with a stylized flourish at the end.

James Cosgrove  
Director, Health Care

# Appendix I: Comments from the Department of Health and Human Services



A T

Assistant Secretary for Legislation  
Washington, DC 20201

DEC 12 2012

James Cosgrove  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Mr. Cosgrove:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "MEDICARE PHYSICIAN PAYMENT: Private Sector Initiatives Can Help Inform CMS Quality and Efficiency Incentive Efforts" (GAO-13-160).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE PHYSICIAN PAYMENT: PRIVATE SECTOR INITIATIVES CAN HELP INFORM CMS QUALITY AND EFFICIENCY INCENTIVE EFFORTS" (GAO-13-160)**

The Department appreciates the opportunity to review and comment on this draft report. We agree with GAO's recommendation that as CMS continues to implement and refine the Value Modifier program to enhance the quality and efficiency of physician care, the Administrator should consider whether certain private sector practices could broaden and strengthen the program's incentives.

**GAO Recommendation**

Develop at least some performance benchmarks that reward physicians for improvement as well as for meeting absolute performance benchmarks.

**HHS Response**

HHS concurs with the recommendation and will consider developing performance benchmarks in the near future. Our focus for the first year of the Value Modifier was to design a program that reinforces CMS's existing physician quality reporting program. We believe that reporting is a necessary first step towards improving quality. Until we have greater physician reporting on quality measures, we will not be able to develop meaningful high performance benchmarks or improvement targets.

**GAO Recommendation**

Make Value Modifier adjustments more timely in order to better reflect recent physician performance.

**HHS Response**

HHS concurs with the recommendation, and CMS indicated in the 2013 Physician Fee Schedule Final rule with comment that we are examining ways to close the gap between the Value Modifier performance period and the payment adjustments. Currently, we have established 2013 and 2014 as the respective performance years for the Value Modifier that applies during calendar year 2015 and 2016. We are planning to provide performance feedback reports to groups within approximately nine months after the close of the performance period. As stated in this report, the interval between the performance period and the initial feedback reports is needed to capture a lag in quality data submissions (up to three months after the end of the year). In the remaining interval until the Value Modifier is applied for a year, we adjust claims to standardize for price and risk, and conduct quality assurance testing. We also use this period of time to calculate the quality and cost composites, the benchmarks for the quality and cost measures, and the Value Modifier amounts.

As we continue to gain experience with this program and develop Information Technology solutions for more rapid handling of Medicare claims data and physician-reported quality data, we will look for ways to decrease the gap between the performance period and the application of



**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE PHYSICIAN PAYMENT: PRIVATE SECTOR INITIATIVES CAN HELP INFORM CMS QUALITY AND EFFICIENCY INCENTIVE EFFORTS" (GAO-13-160)**

the Value Modifier while continuing to ensure an adequate period on which to measure performance.

**GAO Recommendation**

Develop a strategy to reliably measure the performance of solo and small physician practices, such as aggregating their performance data to create informal practice groups.

**HHS Response**

HHS concurs with the recommendation. We will seek to develop other strategies to reliably measure the performance of solo and small physician practices. Currently, the Medicare Shared Savings Program currently allows solo and small physician practices to work together on behalf of a patient population to improve the quality and efficiency of care furnished.

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# Appendix II: GAO Contact and Staff Acknowledgments

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## GAO Contact

James Cosgrove, (202) 512-7114 or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, individuals making key contributions to this report include Rosamond Katz, Assistant Director; David Grossman; Kate Nast; and Luis Serna III.

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