Incentives and Recognition

Chapter FastFACTS

1. **PQRI incentives for physicians equal 1% of your total charges in 2011 and 0.5% in 2012 to 2014.**
2. **PQRI penalties begin as a 1.5% Medicare payment reduction in 2015 and increase to 2% after that.**
3. **CMS suggests that those new to PQRI begin with the preventive care measures group for 30 patients.**
4. **Recognition of your quality achievements can be a good marketing tool.**
5. **Participating in reward or incentive programs can reduce your malpractice risk.**

What could new quality strategies offer your practice? For the Everett Clinic, a multispecialty group based in Everett, Wash., the answer included not only greater physician satisfaction, better patient outcomes, and stronger ties to its local hospital, but also a financial boon. By participating in Medicare's Physician Group Practice (PGP) Demonstration, the group found that its new efficiencies saved thousands of dollars; in addition, it has earned $916,000 to date in performance payments for quality and efficiency.

The Everett Clinic, with 16 regional clinics and more than 200 primary care physicians, was one of 10 group practices selected to participate in the five-year demonstration, which ended in March 2010. During that time, the practices continued to receive regular Medicare fee-for-service payments but could also earn performance payments based on cost efficiency and performance

Tough Times Deserve a Little Fun.

The fun begins "now" on the inside back cover.

NOW, *Doctor's Digest* Crossword Puzzles,

written by
L.A. Times Sunday Magazine
puzzler **Myles Mellor** in
every *Doctor's Digest* issue
and on our new iPad App!
Myles Mellor, one of the most published crossword writers in the world, will be creating challenging crossword puzzles for each 2011 issue of *Doctor's Digest*, and monthly for our free iPad App, *Doctor's Digest Practice Solution Center™*!
Try them out! To get advanced notice of our iPad App launch date and to be put on our puzzle subscriber list, please email us at *LShevrin@doctorsdigest.net* and put **PUZZLE** in the subject line.

on 32 quality measures that were phased in over the five years. After the second year of the program, the Everett Clinic and three other participating groups were awarded a total of $13.8 million in performance payments for improving quality and efficiency. "The care improvement we made on transitions [from the hospital] was a big win for patients and providers," Dr. Lee says.

How the Incentives Worked

Incentive payments motivated PGP participants to integrate new strategies and tools into their practices in order to improve quality and efficiency. For example, the Everett Clinic introduced nurse-coaches to guide hospitalized patients in their transition back to primary care. Clinical concerns identified by the nurse-coaches showed up as reminders in the patient's EHR, and physicians followed up with the patient within 10 days to discuss those issues or questions. "The idea is to use electronic tools to track performance and to take that information so we can correct deficiencies and develop a strategic plan for the next visit," Dr. Lee explains.

The new strategy paid off for both quality and the bottom line: After using nurse-coaches for a year, the percentage of hospitalized seniors who had a doctor's appointment within 10 days of leaving the hospital rose from 38% to 60%, and readmissions decreased to 10%—half the national average. The hospital coach initiative led to almost $300,000 in Medicare cost savings during its second year of participation due to fewer emergency room visits, fewer complications, and fewer re-hospitalizations, according to an Everett Clinic report. Overall, the Everett Clinic saved Medicare nearly $1.6 million in the second year of the demonstration and $400,000 in the first year. The clinic did not generate savings for years three and four.

Under the demonstration program, after reducing billing to CMS by a threshold of 2%, participating groups could earn performance payments of up to 80% of the savings they generated; Medicare retained at least 20%. Performance payments were based on a combination of cost efficiency for generating savings and a practice's scores on quality measures, with the quality portion gradually given more weight over the course of the demonstration as more measures were added. By year five, half of a

practice's incentive payment was based on cost efficiency and half on achieving QI targets. Measures focusing on diabetes were introduced in year one, followed by congestive heart failure and coronary artery disease in year two, and hypertension and cancer screening in years three, four, and five.

It's encouraging that payers and quality organizations are starting to recognize and reward physicians for improving quality. "A lot of the things we can do to help people manage their diseases better are hard to sustain because the current reimbursement drivers are misaligned to doing the things we know will work," Dr. Meyers says. "But it is an exciting time because people are starting to recognize this; so we have pay-for-performance and care-management fees for primary care physicians. Those payments are starting to provide the resources practices need to improve chronic care management."

Tapping Into Financial Rewards

Some large groups are already using PQRI as a basis for awarding performance bonuses to providers. Summit Medical Group, for example, distributed its 1.5% PQRI bonus last year to its 265 physicians based on individual compliance with the PQRI's 179 measures, Dr. Brenner says. "Individuals get bonuses based on their ability to comply with those metrics and reach goals," he explains.

To get started with PQRI, physicians have to choose which quality measures to report on—to qualify, they have to choose at least three individual measures or one measures group—and a method of reporting. (For a list of the 2010 measures, see For More Information, page 63.) Data can be reported directly to CMS via Part B claims or a qualified EHR, or through a qualified PQRI registry (a list of qualified registries can be downloaded from the CMS Website). For the 2010 reporting year, practices that submitted the necessary data were eligible for an incentive payment equal to 2% of their total estimated allowed charges under the Part B physician fee schedule. After 2010, you can still earn meaningful incentives equal to 1% of total charges in 2011 and 0.5% in 2012 to 2014. Participation is voluntary, but those who hold out will incur penalties in the form of a Medicare payment reduction of 1.5% in 2015 and 2% after that.

Billings Clinic began participating in PQRI when the program was integrated into the PGP Demonstration in 2007. After exceeding target goals on 98% of the quality measures that year, the group received a PQRI incentive payment of $348,000. "PQRI may not seem like a big deal, but it shows that Medicare is shifting toward pay-for-performance," Dr. Carr says. "[Payers] are looking for providers that provide value—not the lowest unit cost but the overall cost of care for meeting quality measures. Pay-for-performance is a financial savings and efficiency model, but you're required to meet quality measures to realize those savings."

Geisinger Health System also benefited financially from participating in the PGP demonstration. The Danville, Pa.-based system, comprised of three medical centers, a 700-member group practice, a nonprofit health insurance company, and a health research center, improved quality on all 32 performance measures, including programs for diabetes, coronary artery disease, hypertension, and preventive care. The group did not earn incentive payments in the first two years of the program, partly because it was investing in new services and management techniques that would help generate future savings, said Thomas Graf, MD, who leads a group of 200 primary care physicians as chair of Geisinger's Community Practice Service Line. But those investments paid off in the second two years of the demonstration when Geisinger earned $2 million in incentives each year. Geisinger primary care physicians earn 20% of their total cash compensation from quality criteria such as this; the average quality bonus was $15,000 with maximal payments up to $30,000 annually. Their payments for the fifth year have not yet been announced.

The PGP demonstration ended in March 2010, but physicians can still enroll in PQRI. To participate, submit data on at least three individual measures or one measures group to qualify for an incentive payment. CMS suggests beginning with the preventive care measures group for 30 patients. To get started, CMS recommends the following steps:

- Select a start date on which you want to begin submitting quality data;
- Identify the next Medicare Part B patient you will be seeing who

is 50 years of age or older and for whom you will bill an evaluation and management code of 99201-99205 or 99212-99215. No specific diagnosis is required for this measures group;
- Report the measures group specific intent G-code (G8486) with your first patient; and
- Refer to the "preventive measures group demographic criteria" table to see which measures apply to the patient based on age and gender.

Getting Recognized for Quality

Going public with quality data may seem intimidating at first. You may feel that the numbers don't accurately reflect the quality of care you're providing in your practice, or you may feel uncomfortable with how your numbers stack up against other physicians or national averages. However, transparency can also bring your practice positive recognition and raise the overall quality of care in your community. "We need to agree on set ways of documenting things because everyone has to document the same way in order to compare," says Douglas A. Magenheim, MD, FACP, general internist and founding partner of the Cincinnati-based My Doctor LLC.

My Doctor, with one other physician, is one of 95 primary care practices across the Cincinnati area participating in Your Health Matters, a Website run by the Health Improvement Collaborative of Greater Cincinnati, which publishes performance reports based on five goals for diabetes care: controlling blood pressure, lowering LDL cholesterol, managing HbA1c values, encouraging smoking cessation, and promoting daily aspirin use. Dr. Magenheim was among a group of primary care physicians who helped develop the site. Visitors to the site can learn a practice's overall diabetes score as well as scores for each measure.

Public reporting programs are a good way to get all patients

to reach evidence-based goals, Dr. Magenheim says. Gathering and reporting data for the Your Health Matters Website also laid the groundwork for applying for national recognition through the NCQA, he adds. The practice received official NCQA recognition for quality in four areas: diabetes, heart/stroke, PCMH, and back pain.

It does take extra effort to complete an NCQA application, and there are accompanying fees based on the number of physicians in the practice. (For more information about this and other programs, go to *www.ncqa.org*.) The fee to apply for the diabetes recognition program, for example, is $500 for one physician up to a cap of $3,000, plus $80 for a Web-based data collection tool. However, the recognition can be a good marketing tool, Dr. Magenheim says. Additionally, some medical specialty boards credit program recognition toward maintenance of certification requirements.

Reducing Risk

Lowering your malpractice risk is another potential benefit of participating in reward or incentive programs, experts say. Physicians who report progress and outcomes necessarily have to pay more attention to documentation, which is critical if you're faced with a malpractice suit. "If you send someone out for an X-ray, you need to know whether that got done and whether you got the results and the patient was notified," says Dr. Bagley of the AAFP. "The old way was 'no news is good news,' but if an X-ray report never got to the clinician or the patient was not notified—those are the sources of lots of malpractice cases for non-follow-up or failure to diagnose because you didn't leave a paper trail."

Malpractice insurance carriers are starting to recognize physicians who engage in quality improvement, and some carriers provide discounts, says TMF's Mr. Warren. "Malpractice risk comes from issues of communication or gaps in service and coordination of care," he notes. "Quality initiatives help the practice understand the key processes they are responsible for in managing patients and who owns each step of the process." The Doctors Company, for example, a national physician liability insurer, offers a 5% "patient safety credit" to ACP member

physicians who maintain their general internal medicine or subspecialty board certification. (ACP sponsors the company's medical liability program.)

Recognizing these issues, the IHI is partnering on a research study with the Massachusetts Department of Health and Brigham and Women's Hospital, focusing on patient safety issues in office practices, says Dr. Boudreau. "The common issues are missed critical results, medication management errors, and communication with patients—all areas where there can be malpractice risk," she says. "Working on these areas and improving them, particularly if we include our patients in the quality improvement process, can really help to reduce those risks."

Meaningful Use of EHRs

Upgrading technology and purchasing EHRs are major stumbling blocks for many small practices on the road to QI. Many cannot afford the financial and time commitment associated with buying and customizing systems, training staff, and adjusting workflow. As a result, many welcomed the federal government's decision to provide financial incentives to help with EHR adoption. However, there are strings attached. In order to qualify for incentives, physicians must comply with "meaningful use" objectives set by the Department of Health and Human Services (HHS). By meeting minimum requirements, eligible physicians may receive as much as $44,000 towards EHR purchase.

The final rule on meaningful use consists of 25 objectives, 20 of which must be met to qualify for incentive payments, according to HHS. For 2011 to 2012, physicians must meet 15 required core objectives and choose 5 others from a menu set of 10. Physicians must also report on a total of 6 clinical quality measures consisting of 3 required core measures or alternate core measures and 3 additional measures selected from a set of 38, which include measures such as diabetes blood pressure management, breast cancer screening, and asthma assessment.

Since small practices "may not have the resources or expertise or time to do QI," it's especially important for them to take advantage of EHR incentives as well as assistance from QIOs and regional extension centers, says Mr. Warren. "Be aware of the resources available."