The Advantages and Challenges of Measuring Patient Experience in Outpatient Clinical Practice. Part 1: Current Medicare Physician Quality Reporting Programs

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Am J Gastroenterol 2016; 111:449–450; doi:10.1038/ajg.2016.82; published online 5 April 2016

The transition of health-care from a traditional fee-for-service system to a value-based system will put pressure on physician practice groups to deliver high-quality and cost-effective care while also providing a positive patient experience. It is critical that physician practice groups of all sizes take the necessary preparatory steps. This is the first of a four-section report from the ACG Practice Management Committee that sets out to explain the current quality reporting programs, relate the history of patient satisfaction in health care, explain the relevance of the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) to clinical practices, and describe methods of acting on results in an effective manner.

Value has been succinctly defined as quality divided by cost ($V=Q/C$). That is, value-based care means achieving the best outcomes at the lowest cost. The goal of the Federal Government is to decrease costs while increasing the quality of services delivered (1). This is expected to be accomplished through the concept of Value-Based Purchasing (VBP), which is a demand-side strategy to measure, report, and reward excellence in health-care delivery (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing). VBP involves the actions of coalitions, employer purchasers, public sector purchasers, health plans, and consumers in setting reimbursement rates that take into consideration access, price, quality, efficiency, and alignment of incentives (2). High-performing health-care providers will be rewarded with improved reputations through public reporting, potentially enhanced reimbursements, and increased market share through purchaser, payer, and/or consumer selection. In essence, reimbursement for delivered health-care services will be made based on quality and cost.

Patient satisfaction (PS) is part of the "quality" portion of the "value equation". Quality is generally defined by adherence to nationally recognized quality metrics and best-practice models, including those developed and endorsed by professional medical societies. This assumes attaining and increasing quality and safety for patients can be accomplished by following nationally recognized metrics as these tend to be objective and based on evidence-based medicine. A more subjective component of quality is measurement of PS specifically through CG-CAHPS.

There are presently three quality reporting programs to which physicians must report quality-related data and through which Medicare will issue public "report cards" on physician quality (**Figure 1**). Failing to participate in these programs will result in penalties through reduced reimbursements.

1. Under the Physician Quality Reporting System (PQRS), physicians must document and report on the care they provide through a set of clinical quality measures (3). There are hundreds of measures to choose from, including PS. Between 2015 and 2017, practices of various sizes will be required to report on CG-CAHPS survey results as a mandatory PQRS measurement.

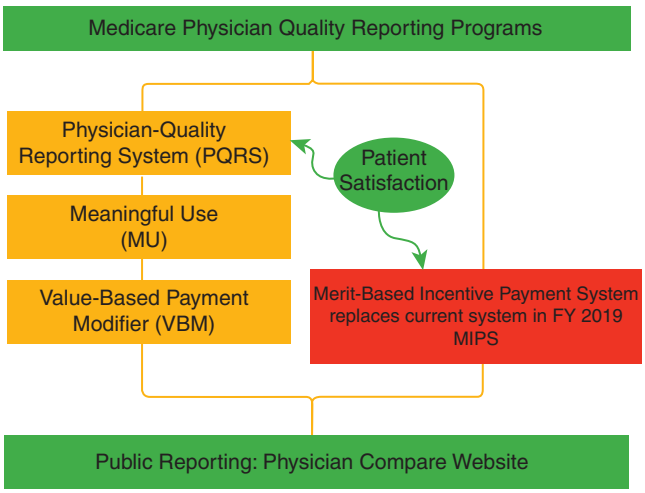

Figure 1. Measurements of patient satisfaction in current and future CMS physician quality reporting programs.

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Performance categories	Year 1 (2019)	Year 2 (2020)	Year 3 (2021)	2022- forward
Quality	50%	45%	30%	30%
Resource use	10%	15%	30%	30%
Clinical practice improvement activities	15%	15%	15%	15%
Meaningful use[1]	25%	25%	25%	25%
Maximum annual payment reduction[2]	–4%	–5%	–7%	–9%
Maximum annual positive adjustment [3, 4]	Bonus may not exceed 12%	Bonus may not exceed 15%	Bonus may not exceed 21%	Bonus may not exceed 27%

1. MU weight can decrease to 15% and be redistributive if EHR adoption reached 75%
2. Budget neutrality rule: the payment cuts for each year must equal the total payment bonuses
3. Allocation from pool of funds of providers receiving payment cuts: per provider bonus capped at 3x of the actual maximum cut.
4. 2019 – 2025: providers in highest 10% of scores receive additional positive adjustment factor (no budget neutrality). $500 million is available each year for 6 years. Bonus capped at 10% of funds per provider.

Figure 2. Proposed construct for the Merit-Based Incentive Payment System (MIPS).

2. The Medicare Electronic Health Records Incentive Program or "meaningful use (MU)" program requires physicians to demonstrate that they are using certified electronic health record technology to improve quality, safety, and efficiency in their practices (4). Compliance criteria increase over time across three stages that focus on data capture and sharing (Stage 1); advanced clinical processes (Stage 2); and improved outcomes (Stage 3). These programs are currently be revised.
3. The value-based payment modifier (VBPM) adjusts physician payments based on the quality data they report to PQRS and on Medicare cost data (5). Payments to large practices faced adjustments in 2015 based on the data reported for 2013, and 2015 "performance year" data will determine the payments for all physicians in 2017. The VBPM determines payments by comparing the quality index value (based on selected PQRS measures) with a cost index value (based on *per capita* physician and hospital costs attributed to the physician). Again, this can be summarized to a simplified equation where Value (*V*)=Quality (*Q*)/Cost (*C*).
4. The public element to quality reporting is accomplished through the Physician Compare website (http://www.medicare.gov/physiciancompare/), which displays quality ratings from physicians' quality performance scores.

PQRS penalties started at 1.5% in 2015 (based on 2013 reporting) and remain a flat 2% starting in 2016. MU penalties increase over time (2–5%) depending on the number of "meaningful users" during that year. VBPM payment reductions or incentives will depend on group-practice size and performance in the various programs.

THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

On 16 April 2015, President Obama, with bipartisan congressional support, signed into law the Medicare Access and CHIP Reauthorization Act, which included language to harmonize and streamline the existing quality reporting programs under one "merit-based incentive payments system (MIPS)". The final form of this streamlining process is still being defined, but organizations like the ACG may be able to make the process clinically relevant and fair for physicians. The four stated categories for the MIPS process are quality, resource use, MU, and clinical practice improvement activities (**Figure 2**). At this time, plans are to replace the current system with MIPS in 2019.

CONFLICT OF INTEREST

Guarantor of the article: Louis J. Wilson, MD, FACG.
Specific author contributions: All three authors played equivalent roles in finalizing the content of the manuscript, interpreting the information conveyed in the manuscript, and drafting the manuscript.
Financial support: None.
Potential competing interests: None.

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