Quality measures for neurologists

Financial and practice implications

Adam B. Cohen, MD

Amy E. Sanders, MD, MS

Rebecca J. Swain-Eng, MS

Gina Gjorvad

Sarah T. Tonn, MPH

Christopher T. Bever, Jr., MD, MBA

Eric M. Cheng, MD, MS

Summary

Measuring and reporting health care quality is increasingly becoming part of clinical practice and reimbursement for specialists, including neurologists. The goal is to improve the value of care. Current major programs tie quality measurements to reimbursement, including programs from the Centers for Medicare and Medicaid Services: the Physician Quality Reporting System, the Electronic Health Record Incentive Program (and Meaningful Use), and Accountable Care Organizations. Many specialty boards, including the American Board of Psychiatry and Neurology, now require clinical practice quality measurements for maintenance of certification. Practitioners may find these programs confusing, overlapping, burdensome, and not clearly relevant to promoting better patient care. Yet, integrating quality metrics into practice has entered the mainstream and is increasingly tied to reimbursement. Further, over the next few years, most programs will switch from bonus incentives for participation to penalties for nonparticipation. This article aims to clarify current and rising quality measurement programs relevant to neurologists.

Departments of Neurology and Radiology (ABC), Massachusetts General Hospital, Harvard Medical School, Boston; Saul R. Korey Department of Neurology (AES), Albert Einstein College of Medicine, Yeshiva University, Bronx, NY; American Academy of Neurology (RJS-E, GG, STT), Minneapolis, MN; Neurology and Research Services (CTB), VA Maryland Health Care System and Department of Neurology, University of Maryland School of Medicine, Baltimore; Department of Neurology (EMC), VA Greater Los Angeles Healthcare System, Los Angeles, CA; and Department of Neurology (EMC), David Geffen School of Medicine, University of California, Los Angeles.

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Correspondence to: abcohen@partners.org

Measuring health care quality is not new. For the past several decades, measures developed by the National Committee for Quality Assurance have been used to assess the quality of care provided by health care plans.¹ Core hospital measures originally developed by the Joint Commission have been used to certify hospitals.² However, quality measurement at the individual practitioner level, particularly for specialists, and tying performance to these measures, is new. (Practitioners, for the purposes of this review, are defined as any clinician who can bill: allopathic or osteopathic physicians, physician's assistants, and nurse practitioners.) These changes are part of an effort by policy makers to change the current fee-for-service health care system, which incentivizes volume of services, to a value-based system, which incentivizes high-quality care.^{3,4}

Neurologists have not yet been widely required to participate in quality measurement programs. However, participation will soon be required. Quality measurement programs will soon switch from the current practice of providing incentives for participating to levying penalties for not participating. Accordingly, there will be greater interest and participation among neurologists. Members of the American Academy of Neurology's Quality Measurement and Reporting subcommittee have written this article to provide an overview of current high-profile measurement programs relevant to neurologists.

Physician Quality Reporting System

In 2007, the Centers for Medicare and Medicaid Services (CMS) implemented the Physician Quality Reporting System (PQRS), a pay-for-reporting program that provides financial incentives to eligible professionals who report data on quality measures for covered services furnished to Medicare beneficiaries. Measures have been added to the PQRS each year since its inception and there are over 300 measures in the 2013 program.⁵

The incentives for participating in PQRS are both financial and reputational. The program began with incentive payments equal to 2% of the practitioner's total Medicare Part B Physician Fee Schedule charges for all covered services provided during the year. In 2012, the incentives decreased to 0.5% and will soon switch to penalties. Thus, practitioners who elect not to participate or are determined to be unsuccessful during the 2013 program year will receive a 1.5% payment penalty in 2015, and a 2% penalty thereafter. In addition, CMS plans to publish the names of practitioners who successfully participate in PQRS on the *PhysicianCompare* Web site, which helps patients locate practitioners who accept Medicare.⁶ CMS is also considering whether to also highlight practitioners who do not participate in PQRS.

PQRS has proven to be daunting to those trying to understand its requirements and implement the measures in practice time. Practitioners must first determine the PQRS reporting option that best fits their practice: claims-based, registry-based reporting, or group reporting. Solo neurologists or single-specialty neurology practices will not choose group reporting because these measures are geared toward the primary care provider. Neurologists will only choose group reporting measures if they are included as part of a larger multispecialty group that contains many internists and family practitioners. Next, practitioners choose a 6- or 12-month reporting option. The practitioner then reviews the list of PQRS measures. There are separate lists of measures depending on whether one chooses the individual measures or the group measures option. Table 1 lists the clinical topics for individual PQRS measures specific to neurology, such as stroke and epilepsy. Group measures also exist for Parkinson disease, dementia, sleep, and back pain. Neurologists are also eligible to choose general measures, such as falls screening, pain management, depression, medication reconciliation, back pain, and smoking cessation.

As an example, PQRS measure #266 requires documentation of seizure types and current seizure frequencies for each seizure type for all patients with a diagnosis of epilepsy. The eligible patient population includes patients with epilepsy diagnoses (*ICD-9* diagnosis codes 345.xx). The requirement mandates documentation of seizure types and frequencies at all visits for these patients during the measurement period, unless specified exclusion criteria are met. This documentation is performed by chart abstraction or entering specific Current Procedural Terminology (CPT) II

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codes and E/M codes into the (Part B 1500) billing form and medical record. CMS reserves the right to audit charts to confirm that documentation matches quality measure reporting.

The top 5 PQRS measures used by neurologists are presented in table 2 (source: American Academy of Neurology [AAN]). This shows that a neurologist does not have to use neurology-specific measures to participate. Two of the top 5 are general measures: use of an electronic health record (EHR) and documenting medications. Two others focus on tobacco use, and the fifth one regards deep vein thrombosis prophylaxis for stroke patients. For comparison, the top 5 PQRS measures for neurosurgeons and internists appear more specific to their specialties. For neurosurgery, 4 pertain to perioperative care, and 1 to EHR use. For internists, 4 address diabetes and coronary artery disease care, and 1 EHR use.

In 2010, 17% of neurologists participated in PQRS, and 58% of those who participated successfully attained the bonus. In the previous year, only 13% of neurologists participated. In 2010, PQRS incentive payments totaled \$391,635,495, which were paid to 168,843 practitioners and 19,232 practices. The average incentive was \$2,157 per practitioner or \$20,364 per practice. Of the participating neurologists in 2010, 12% used the individual measures reporting option and 49% succeeded in obtaining the bonus. Five percent of participating neurologists used the registry reporting option and 84% of them obtained the bonus. Finally, 0.7% of participating neurologists used the group reporting option and 95% succeeded in obtaining the bonus.

Further instructions and details are published on the CMS Web site.^{5,7} The AAN Web site also publishes further details of the PQRS measures likely to be relevant to neurologists. Practitioners are advised to periodically review these sites to learn about changes relevant to each year's program. The AAN also notifies members of yearly changes to the program.

Maintenance of certification

Maintenance of certification (MOC) is recognized as an important quality marker by hospitals, payers, and credentialing organizations. All specialty boards of the American Board of Medical Specialties (ABMS), including the American Board of Psychiatry and Neurology (ABPN), have

Table 1 Selected topics (and number of quality measures) in the Physician Quality Reporting System relevant to neurologists

Epilepsy (3 by claims)
Stroke (4 by claims, 6 by registry)
Sleep apnea (4 by registry)
Parkinson disease (6 by registry)
Back pain (4 by registry or claims)
Dementia (9 by registry or claims)
There are over 300 Physician Quality Reporting System measures, including general measures that apply to patients of all conditions.

Table 2 The 5 most commonly used Physician Quality Reporting System measures by all neurologists, neurosurgeons, and general internists**Top 5 Physician Quality Reporting System (PQRS) measures used by neurologists:**

1. Adoption and use of electronic health record (PQRS #124)
2. Inquiry regarding tobacco use (#114)
3. Documentation and verification of current medications in the medical record (#130)
4. Advising smokers to quit (#115)
5. Deep venous thrombosis prophylaxis for ischemic stroke or intracranial hemorrhage (#31)

Top 5 PQRS measures used by neurosurgeons:

1. Perioperative care: timing of antibiotic prophylaxis (PQRS #20)
2. Perioperative care: selection of prophylactic antibiotic—first- or second-generation cephalosporin (#21)
3. Adoption and use of electronic health record (#124)
4. Perioperative care: venous thromboembolism prophylaxis (#23)
5. Perioperative care: discontinuation of prophylactic antibiotics in noncardiac procedures (#22)

Top 5 PQRS measures used by internists:

1. Hemoglobin A1c poor control in diabetes mellitus (PQRS #1)
2. Low-density lipoprotein control in diabetes mellitus (#2)
3. High blood pressure control in diabetes mellitus (#3)
4. Adoption and use of electronic health record (#124)
5. Coronary artery disease: antiplatelet therapy (#6)

implemented new requirements for self-measurement of quality with a Performance in Practice (PIP) component.^{8–10} Since 1994, the ABPN has increased requisites for MOC to include a written test, continuous medical education credits, and self-assessment testing.

For those who recertify in 2014, ABPN will require that neurologists complete 1 approved PIP module. PIP modules have the neurologist identify 5 cases from clinical practice, assess their performance through quality measures, complete an education module on areas of identified practice gaps, and then remeasure performance after completion of the education module. Various organizations and institutions, including the AAN, have developed PIP component modules for MOC.^{11,12} Whenever possible, the AAN has attempted to harmonize PIP measures with those used in other programs such as PQRS, but the breadth of NeuroPI topics is greater than those offered through PQRS.

PQRS also offers a MOC:PQRS program to eligible practitioners performing MOC activities for participating medical boards. These practitioners can earn a 0.5% additional incentive with successful PQRS participation. In 2012, there are 9 participating ABMS Medical Boards, but not the ABPN. However, the ABPN will consider applying for an ABPN MOC program in 2013 (personal communication, AAN, 2012). In contrast to standard MOC activities, the MOC:PQRS program requires more frequent participation.

CMS also offers a 0.5% incentive payment to practitioners for completing the PIP component of MOC. In order to qualify, the practitioner must complete more PIP modules than what is required for MOC alone. One year of previous successful participation in PQRS is also requisite.

Meaningful use

In 2010, CMS implemented the meaningful use (MU) program, an incentive program for practitioners and hospitals that attest that they have “meaningfully used” their EHR by satisfying a set of objectives (e.g., entering an allergy on every patient) and quality measures (e.g., obesity

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counseling) and submitting the data to CMS.^{13–15} The MU program is complex. There is a hospital program as well as a provider program. Both hospitals and providers can choose between the Medicaid and Medicare MU programs. For providers, the eligibility for the Medicaid MU program is a practice of at least 30% Medicaid; that threshold is reduced to 20% for pediatricians. Providers who qualify for both Medicare and Medicaid MU usually choose the Medicaid program because the incentives are higher and the attestation schedule is less strict.

Because Medicaid is run by the state, some rules vary by state, so a provider must check individual state rules.¹⁶

In 2012, the Medicare version of MU provided incentives up to \$44,000 over 5 years to practitioners who successfully meet requirements. Like PQRS, these incentives will decrease and eventually convert to penalties. Providers who do not attest for MU by 2015 and in each subsequent year are subject to penalties that start at 1% of their Medicare reimbursement per year, up to a maximum 5% annual adjustment. For the Medicaid program, a provider can start attesting as late as 2016 and still qualify for the maximum incentives.

The requirements of the MU program are also among the most complex of all the current CMS incentive programs, so only a summary can be described in this article. The objectives are unique to MU and typically have no such equivalent in other quality programs. Some objectives require considerable attention because a threshold is attached to them. For example, to satisfy the allergy objective, a provider must document an allergy or that no allergies exist for at least 80% of their patients. If a provider fails to meet any of the thresholds, that provider will be unable to attest for MU.

The MU quality measures require special attention. Unlike the MU objectives, there is no threshold attached to the quality measures; providers receive equal credit for performing obesity counseling on nearly all of their patients vs just a few of them. However, unlike PQRS, the MU reports are automated, which disallows manual reporting of the delivery of a particular care process. In PQRS, the correct CPT II code is manually added to the billing form. In MU, the EHR must generate an accurate report showing the timing and completion of a care process.

One key decision is choosing appropriate quality measures to report. There are 44 ambulatory MU quality measures. All of the 44 MU measures have a counterpart among the 268 individual PQRS measures, but of course, the reverse is not true. Unfortunately, none of the ambulatory MU quality measures are specific to neurologists. Therefore, neurologists who participate in both PQRS and MU programs must decide whether to implement quality measures specific to neurology for PQRS and a different set of non-neurology-specific quality measure for MU. Alternatively, a neurologist may decide to pick the same quality measures to satisfy both programs, but currently, they will not be neurology-specific measures.

There is also a hospital version of MU, which includes stroke quality measures that overlap with Core Measures established by the Joint Commission. Some neurologists may be able to leverage their position as stroke champions to obtain further resources from the hospital to help attest for MU. However, neurologists who help hospitals obtain MU incentives must also participate in the provider MU program to avoid penalties.

In data available up to June 2012, there were 1,611 neurologists (out of 62,177 total providers across specialties) who successfully attested for the Medicare MU program. So far,

Table 3 The 33 quality measures for evaluating Accountable Care Organizations

Domain	Items
Patient experience (7)	<ul style="list-style-type: none"> • Timely appointments; communication; overall rating; access to specialists; health promotion; shared decision making; health status/functional status
Care coordination and patient safety (6)	<ul style="list-style-type: none"> • Readmission/admission (3) • Process measure for falls • Electronic health record use • Medication reconciliation
Preventive health (8)	<ul style="list-style-type: none"> • Cancer screening (2) • Immunization (2) • Atherosclerosis (blood pressure, weight, smoking) management (3) • Depression screening
At-risk population (12)	<ul style="list-style-type: none"> • Process measures about atherosclerosis management (5) • Physiologic outcome measures about hemoglobin A1c, blood pressure, low-density lipoprotein, tobacco use status (7)
The number of measures for each category or subcategory is placed in parentheses.	

incentive payments to neurologists have been \$28 million (compared to about \$1 billion to all providers across specialties). For further details, consult the AAN and CMS sites.^{17,18}

Accountable Care Organizations

A provision of the Affordable Care Act (signed by President Obama in 2010 and upheld by the Supreme Court in 2012), the Medicare Shared Savings Program (MSSP), established guidelines for Accountable Care Organizations (ACOs).^{19,20} An ACO is a network of practitioners and hospitals that manages a population of at least 5,000 Medicare beneficiaries. Unlike PQRS and MU, the measures for assessing ACOs are evaluated at the group level rather than the individual practitioner level. However, ACO measures fundamentally differ in concept from the programs discussed previously, and even though the financial implications are not applied at the individual practitioner level, they warrant separate discussion.

The MSSP places ACOs at financial risk for managing a population of patients. Using prior costs, Medicare calculates a target level of spending for the ACO to manage the particular population. If ACOs manage this population using less money than projected, they will split the savings with Medicare. The concept of putting health care practitioners at financial risk is similar to that of capitation used by health maintenance organizations (HMOs) in the 1990s. Capitation was widely disliked: HMOs were perceived as saving money by denying health care. To counter this perception, the MSSP also requires that ACOs meet performance goals on 33 quality measures (table 3) in order to receive savings.

A few ACO measures are similar to the measures in the PQRS, MU, and MOC programs. Other measures may be less familiar to neurologists, such as patient perception measures. These include patient experience scores on access to specialists, how well the doctors communicate, and timeliness of care, appointments, and information. Outcome measures include the physiologic control of atherosclerotic risk factors as well as hospitalizations and readmissions for certain high-risk populations.

DISCUSSION

Quality measurement is being increasingly adopted in specialty health care through programs by organizations for quality improvement, accountability, public reporting, accreditation, certification,

and payment. The impact of quality measures on practice and reimbursement will increase as they become more closely tied to penalties and public reporting. Incentives will evolve into penalties, the latter of which will be cumulative across programs. In 2016, a practitioner may be subject to a 2% penalty by the PQRS program and a 5% penalty by the MU program.

CMS continues to add quality measures to existing programs and develop new programs. Although all quality measurement programs are beyond the scope of this review, others exist, such as the Physician Value-Based Modifier Program and pay-for-performance programs run at state and health plan levels.²¹

Practitioners want harmonization of measures across programs and decreased burden of documenting the measures. The next stage of the MU program will better harmonize with PQRS and the core measures required by the Joint Commission. The AAN will continue to work on developing measures relevant to neurologists and patients, monitor government programs, and advise members on how to navigate this evolving landscape.

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