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Evaluating Physician Compare: Benefits and Challenges of Scorecards for Individual Physicians

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EVALUATING PHYSICIAN COMPARE: BENEFITS AND CHALLENGES OF SCORECARDS FOR INDIVIDUAL PHYSICIANS

*Rebecca Gittelson**

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INTRODUCTION

Changes in the healthcare industry call for patients to become increasingly involved in managing their own care and for physicians to take more responsibility for improving the quality of care they provide.¹ As part of the Patient Protection and Affordable Care Act, the Centers for Medicare and Medicaid Services was tasked with developing and publishing public scorecards, or report cards, on the quality of care provided by certain physicians.² That mandate has taken the form of Physician Compare, a federal website that publishes scorecards on individual physicians, and is intended to empower patients with additional information to make informed healthcare choices and to incentivize physicians to perform well.³

The objective of this article is to examine the feasibility, benefits, and challenges of the federal Physician Compare scorecard website for individual physicians. Section I will discuss the problems of healthcare quality and cost the United States faces. Section II will cover the federal government's use of public reporting regulations to address cost and quality problems in the American healthcare system. This section will include a brief overview of the National Practitioner Data Bank and a description of Physician Compare, the federal website that is designed, in part, to publish scorecards for individual physicians. Section III will analyze the feasibility of Physician Compare by examining the data used for Physician Compare, stakeholder engagement in the reporting and publication process, incentives for participation in Physician Compare, and website design.

Finally, this article concludes by arguing that Physician Compare may be able to fulfill its worthy goals of improving patients' engagement in their own healthcare choices and incentivizing physicians to provide better quality care. Physician Compare faces many challenges, however, in achieving these aims. In particular, Physician Compare has stumbled in developing both patients and physicians' basic knowledge of the site, which adversely affects their level of engagement with the site. The site generally lacks transparency around the data and analysis methods utilized to develop the quality metrics that are published. Physician Compare has also struggled to strike an effective balance between publishing comprehensive data while making the site understandable and user-friendly for patients and physicians. Without changes in these areas, patients and physicians will not realize the full benefits attainable from Physician Compare.

I. PROBLEMS OF HEALTHCARE QUALITY AND COST IN THE UNITED STATES

The health care policy discussion is dominated by concerns over cost, quality, access, and choice. The ultimate goal seems clear: increasing quality and decreasing cost in United States healthcare, while retaining patient choice.⁴ However, the way to reach this goal is not obvious.⁵ Defining quality is challenging, though the Institute

¹ See *infra* Section I.

² See *infra* Section II.C.

³ See *infra* notes 54–57.

⁴ See BARRY R. FURROW ET AL., *THE LAW OF HEALTH CARE ORGANIZATION AND FINANCE* 40–41 (7th ed. 2013).

⁵ See *id.*

of Medicine provides a useful starting point: “quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”⁶ Yet, even with this definition, the exact meaning of quality is still a moving target. Unanswered questions about the meaning of quality include how cost to patients fits in; the role of equity in access to care across the population; and whether quality simply means providing only needed care.⁷

Despite debate over the exact meaning of quality, there is agreement that quality and cost in the United States health care market must improve. The United States spends more per capita on healthcare than any other developed country⁸ but has significantly worse outcomes, particularly death from treatable conditions.⁹ Wasteful spending constitutes up to half of the \$2.2 trillion the United States spends annually on health care.¹⁰ A majority of consumers say that inefficiency in the health care system not only drives up cost but also decreases quality.¹¹ A recent study found that a decade of dramatic increases in health care spending (from 1999 to 2009) wiped out any income gains the average American family would have accrued in that period.¹²

In addition to healthcare system-wide problems of low quality and high cost, it is also extremely challenging for patients to find and understand information about how much their care will cost and the quality of that care. Two key market failures that explain this difficulty are (1) asymmetries in information and (2) agency relationships.¹³

Asymmetries in information, the first market failure, occur when disparate information is available to patients and physicians.¹⁴ Because of the technical and complicated nature of information about diagnosis, treatment, and outcome, it is strikingly difficult in the current system for patients (and payers)¹⁵ to evaluate quality and cost of services.¹⁶ At a basic level, it is challenging for patients to acquire the information

⁶ *Id.* at 27–28 (quoting DIV. OF HEALTH CARE SERVS. INST. OF MED, *MEDICARE: A STRATEGY FOR QUALITY ASSURANCE* 20 (Kathleen N. Lohr ed. 1990)).

⁷ *See id.* at 28–29.

⁸ *See Health Spending*, ORG. FOR ECON. CO-OPERATION AND DEV. (2013), <https://data.oecd.org/healthres/health-spending.htm>.

⁹ *See generally* Ellen Nolte and C. Martin Mckee, *Measuring the Health of Nations: Updating an Earlier Analysis Available*, 27 *HEALTH AFF.* 58 (2008).

¹⁰ *The Price of Excess: Identifying Waste In Healthcare Spending*, PRICEWATERHOUSECOOPERS (2010), <http://www.pwc.com/us/en/healthcare/publications/the-price-of-excess.html> (defining wasteful spending as “redundant, inappropriate or unnecessary tests and procedures . . . [as well as] inefficient healthcare administration[,] and the cost of care necessitated by conditions such as obesity, which can be considered preventable by lifestyle changes”).

¹¹ *See id.*

¹² *See generally* David I. Auerbach & Arthur L. Kellerman, *A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains For Average U.S. Family*, 30 *HEALTH AFF.* 1630 (2011).

¹³ *See* FURROW, *supra* note 4, at 10.

¹⁴ *See id.*

¹⁵ *See, e.g., infra* notes 117–123 (describing the controversy over New York insurers’ efforts to quantify quality of care).

¹⁶ *See* FURROW, *supra* note 4, at 10.

necessary to “shop” for health services that are in their best interest.¹⁷ As a result, patients are often passive consumers in how they select physicians.¹⁸ When choosing a physician, patients with poor or fair health status are even less likely than the general population to actively seek out formal quality information and may be more likely to seek out informal advice from friends.¹⁹ Physician scorecards could help all patients become more active consumers in the selection of their physicians by decreasing the cost and time necessary to weigh the costs and benefits of seeking care.²⁰ Moreover, by easing access to information, scorecards could have a particularly positive impact for those in poor health, for whom quality of care may matter more to than the general population.²¹

The second market failure that makes it difficult for patients to access and understand quality and cost information is agency relationships. These relationships occur when people “purchase” health services through at least one agent—an employer that provides and subsidizes their health insurance, their health insurer, and/or their physician—who guides their choices and may be subject to conflicts of interest in that guidance.²² As a result, patients may feel they do not have power over their health care choices, thus contributing to their role as passive consumers. While scorecards are not a cure-all,²³ they may aid patients in gaining more control over their choice of physician²⁴ and allowing them to become better advocates in interactions with these agents.

To remedy these issues, the federal government’s efforts over the years, particularly with the Patient Protection and Affordable Care Act (ACA), have promoted two goals. The first goal is expanding the role of the marketplace through disseminating quality information to consumers so that buyers of health services will reject lower-quality and higher-cost services.²⁵ The second goal is changing reimbursement models through setting and incentivizing quality standards.²⁶

¹⁷ *Id.* at 11.

¹⁸ See Katherine M. Harris, *How Do Patients Choose Physicians? Evidence from a National Survey of Enrollees in Employment-Related Health Plans*, 38 HEALTH SERVS. RES. 711, 712–14 (2003).

¹⁹ See *id.* at 711.

²⁰ See *id.* at 713.

²¹ See *id.* at 714.

²² FURROW, *supra* note 4, at 11.

²³ For example, insurers choose which physicians are included in their covered network of physicians, so patient choice may still be limited even with the use of physician scorecards.

²⁴ See Julia James, *Health Policy Brief: Public Reporting on Quality and Costs*, HEALTH AFF., 1, 1 (2012) http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_65.pdf.

²⁵ See Furrow, *supra* note 4, at 31.

²⁶ See *id.*

II. FEDERAL EFFORTS TO IMPROVE QUALITY THROUGH PUBLIC REPORTING

A. Health Care Quality Improvement Act of 1986 (HCQIA)

Quality reporting as a response to problems in the American health care system has been in place for over twenty-five years, though it has evolved significantly over time.

Congress passed the Health Care Quality Improvement Act (HCQIA) in 1986,²⁷ which is a notable milestone in health care quality reporting because it significantly strengthened federal regulation of physicians and quality of care.²⁸ The HCQIA aimed to improve quality by offering immunity from liability for peer review committees²⁹ and by creating a national, centralized databank for negative actions against physicians.³⁰

For the purposes of this article, the most important element of the HCQIA was the establishment of the National Practitioner Data Bank (the Data Bank) and related requirements. In response to a perceived medical malpractice crisis,³¹ Congress developed the Data Bank to prevent physicians who had disciplinary histories in one state from moving to another state and practicing undetected.³²

Health care entities must report adverse actions, credentialing decisions, and licensure decisions for individual physicians to the Board of Medical Examiners, which is then required to report to the Data Bank.³³ Information in the Data Bank is only available to professional users, including medical boards and hospitals, but not the public.³⁴ If a health care entity fails to report, the Secretary publishes the name of the entity in the Federal Register and the entity is given notice and opportunity to correct its failure; if the entity still does not report, it will lose its civil damages immunity.³⁵ Hospitals are required to check the Data Bank for this information before granting privileges to a physician and every two years thereafter for physicians holding privileges at the hospital.³⁶

From the 1990s onward, states responded to pressure to make information from the Data Bank publicly available by establishing state-run systems to publish this data.³⁷ These systems provide a narrow window into quality of care, as they focus on adverse

²⁷ Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660 § 402, 100 Stat. 3784 (codified as amended at 42 U.S.C. § 11101 (2012)).

²⁸ See Kristin M. Madison, *From HCQIA To The ACA: The Evolution Of Reporting As A Quality Improvement Tool*, 33 J. LEGAL MED. 63, 65 (2012).

²⁹ See HCQIA, 42 U.S.C. § 111111 (2012).

³⁰ See *id.* at §§ 111131–33.

³¹ See, e.g., Elisabeth Ryzen, M.D., *The National Practitioner Data Bank: Problems and Proposed Reforms*, 13 J. LEGAL MED. 409 (1992) (describing the history and requirements of the Data Bank).

³² See 42 U.S.C. § 11101.

³³ See *id.* at § 11133.

³⁴ See *id.* at § 11137.

³⁵ See *id.* at § 11133.

³⁶ See *id.* at § 11135.

³⁷ See Madison, *supra* note 28, at 87–88.

actions, rather than outcomes and process measurements.³⁸ For example, in 1996, Massachusetts created and made available to the public individual physician profiles that included information from the Data Bank, such as education and training, medical malpractice and criminal history, and licensure and hospital actions.³⁹ Most states now provide at least some information on board disciplinary action online, but the breadth of information published varies.⁴⁰ For example, North Carolina required the publication of malpractice information online in 2009.⁴¹ In 2011, Illinois passed the Patient's Right to Know Act, which requires a broader range of information on physicians to be publicly available, similar to the Massachusetts system.⁴²

Although the “Q” in HCQIA stands for quality, the Data Bank provides a limited snapshot of quality.⁴³ The Data Bank only documents information like malpractice settlements and disciplinary actions, not the quality of care provided for a specific condition or even in general.⁴⁴ New reporting systems, such as Physician Compare, have been developed to try to capture more meaningful and comprehensive quality information than that provided in the Data Bank. While new health care quality reporting systems are not perfect, they are more comprehensive than the Data Bank and now usually include “measures of provider quality based on providers’ characteristics (such as education or resources available), the process of care (such as whether care was delivered in accordance with accepted guidelines), or patient outcomes (such as whether a patient dies, is readmitted, or feels better).”⁴⁵

B. The Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) was enacted in 2010.⁴⁶ While much of the ACA is focused on improving access to health insurance,⁴⁷ quality improvement is a central tenet of the Act.⁴⁸ The ACA includes a number of provisions aimed at developing and disseminating reliable data on quality and cost.⁴⁹ The ACA defines quality as “a standard for measuring the performance and improvement of population health or health plans, providers of services, and other clinicians in the delivery of health care services.”⁵⁰ Quality goals include improving patient health outcomes and functional

³⁸ *See id.*

³⁹ *See* Frances H. Miller, *Illuminating Patient Choice: Releasing Physician-Specific Data to the Public*, 8 LOY. CONSUMER L. REV. 125, 127 (1995-1996).

⁴⁰ *See* Meredith Larson et al., *2006 Report of Doctor Disciplinary Information on State Web Sites*, PUBLIC CITIZEN (Oct. 17, 2006), http://www.citizen.org/Page.aspx?pid=700#_ftn3.

⁴¹ 2009 N.C. Sess. Laws 2009-217 (codified at N.C. GEN. STAT. § 90-5.3).

⁴² *See* 225 ILL. COMP. STAT. 61/10 (2015).

⁴³ Madison, *supra* note 28, at 68.

⁴⁴ *See id.*

⁴⁵ *Id.*

⁴⁶ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 26 and 42 U.S.C.).

⁴⁷ *See* Madison, *supra* note 28, at 64.

⁴⁸ *See* FURROW, *supra* note 4, at 32.

⁴⁹ *See id.* at 34.

⁵⁰ 42 U.S.C. § 299b-311 (2010).

status; making patients part of the decision-making process through patient-centered care; and providing care that is timely, effective, safe, efficient, and innovative.⁵¹

Two federal agencies within the Department of Health & Human Services share primary responsibility for public reporting of quality data under the ACA: (1) the Agency for Healthcare Research & Quality (AHRQ) and (2) the Centers for Medicare and Medicaid Services (CMS). The AHRQ is tasked with supporting research on the science of public reporting and setting priorities for improving quality.⁵² AHRQ publishes state- and federal-level aggregate data, and does not report on individual physicians.⁵³ CMS is tasked, in part, with preparing and posting scorecards on hospitals, physicians, and other health care providers who participate in Medicare's new value-based purchasing program, which bases payment partly on whether providers achieve targets for delivering higher-quality care.⁵⁴ As part of this work, CMS is mandated to establish Physician Compare, a website for publicly posting quality data on individual physicians.⁵⁵

C. Physician Compare

Compare websites existed prior to the ACA. For instance, Hospital Compare was created in 2002, with the dual aim of helping patients make more informed decisions about their hospital choices and incentivizing hospitals to provide higher-quality care.⁵⁶ Hospital Compare now publishes quality information on approximately 4,000 hospitals, and the data information available is much more robust than that published on Physician Compare.⁵⁷

Pursuant to its statutory authority under the ACA,⁵⁸ CMS launched Physician Compare in 2010 with a two-fold purpose: (1) to “[p]rovide information to help consumers make informed decisions about their health care; and (2) to “create clear incentives for physicians to perform well.”⁵⁹ At the time of writing, the site has quality data on some group practices, as well as biographical information posted for individual physicians and

⁵¹ See *id.*

⁵² See *id.* at § 299b-33.

⁵³ See James, *supra* note 24 at 2.

⁵⁴ 42 U.S.C. § 1395ww.

⁵⁵ See *id.* at § 1395w-5 (2010).

⁵⁶ See *Hospital Compare*, CMS.Gov, <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/hospitalcompare.html> (last updated June 11, 2015).

⁵⁷ See *What is Hospital Compare?* CMS.Gov, <https://www.medicare.gov/hospitalcompare/About/What-Is-HOS.html> (last visited Nov. 16, 2016) (noting that quality information published on Hospital Compare includes: general information, responses from patient experience surveys, whether the hospital provides timely and effective care, the likelihood a patient will suffer a preventable complication at the hospital, readmission and death rates, use of medical imaging, and payments).

⁵⁸ See 42 U.S.C. § 1395w-5.

⁵⁹ *About Physician Compare: An Overview*, CMS.Gov, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/About-Physician-Compare-An-Overview.html> (last updated Apr. 21, 2016) [hereinafter *About Physician Compare*].

quality data for some individual physicians.⁶⁰ Physician Compare also provides quality data for certain ACOs, although that information is available on a different webpage.⁶¹

1. Data

CMS is publishing information on Physician Compare in two phases, focusing first on group practices and ACOs and then on individual physicians.⁶² Physician Compare has and will only report on physicians,⁶³ group practices, and ACOs that provide Medicare services.⁶⁴ The underlying quality data comes from the Physician Quality Reporting System (PQRS), which is also run by CMS.⁶⁵ PQRS is a “pay-for-reporting program that gives eligible professionals incentives and payment adjustments if they report quality measures satisfactorily.”⁶⁶ Entities choose which PQRS measures they want to report to CMS.⁶⁷ Participants have to report on at least nine measures and meet certain criteria,⁶⁸ but they still have a fair amount of leeway in choosing those measures. In addition, they are required to report on only fifty percent of their Medicare Part B Fee-for-Service (FFS) patients.⁶⁹

The group practice and ACO measures come from a subset of PQRS data known as PQRS Group Practice Reporting Option and ACO GPRO. These measures “encourage[] eligible group practices [and ACOs] to report information about the quality of care they provide to people with Medicare who have certain medical conditions.”⁷⁰ In 2014, CMS published on Physician Compare the 2012 PQRS GPRO Diabetes Mellitus (DM) and coronary artery disease (CAD) metrics for the group practices and ACOs

⁶⁰ See *infra* Section II.c.1.

⁶¹ See *infra* Section II.c.1. and III.d.

⁶² See *About Physician Compare*, *supra* note 59; *infra* Section II.c.1.

⁶³ CMS uses the term “Eligible Professionals” (EPs) to characterize individual providers, but in an effort to minimize the use of additional abbreviations here, this paper will refer to individual physicians. EPs are those who are paid under the Medicare Physician Fee Schedule (PFS) and include, among others: physicians, physician assistants, nurse practitioners, social workers, psychologists, physical therapists, and occupational therapists. *Eligible Professionals*, CMS.Gov, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/downloads/eligibleprofessionals.pdf>.

⁶⁴ See *About Physician Compare*, *supra* note 59.

⁶⁵ See *id.*

⁶⁶ *Id.*

⁶⁷ *How to Get Started: 2016 PQRS*, CMS.Gov, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/PQRS/How_To_Get_Started.html (last updated Nov. 18, 2015).

⁶⁸ See *id.*

⁶⁹ See, e.g., *2015 Physician Quality Reporting System (PQRS): Registry Reporting Made Simple* (2015), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/PQRS/Downloads/2015_PQRS_Registry_Reporting_Made_Simple.pdf. Medicare Part B covers outpatient care, including doctors’ services. See *Signing up for Part A and B*, MEDICARE.GOV, <https://www.medicare.gov/sign-up-change-plans/get-parts-a-and-b/when-how-to-sign-up-for-part-a-and-part-b.html#collapse-3100>.

⁷⁰ *Physician Compare: Physician Quality Reporting System (PQRS)*, MEDICARE.GOV, <https://www.medicare.gov/physiciancompare/staticpages/data/pqrs.html> (last visited Nov. 17, 2016) [hereinafter *Physician Compare: PQRS*].

that successfully participated in PQRS.⁷¹ Later in 2014, CMS published the 2013 PQRS GPRO and Accountable Care Organizations (ACO) DM and CAD measures for 139 group practices, 214 Shared Savings Program ACOs,⁷² and 23 Pioneer ACOs.⁷³ However, it is important to note that although the ACO data is published on a website with Physician Compare in the name, it is actually available on a different page than the data for group practices and individual physicians.⁷⁴

CMS is taking a phased-in approach to publishing quality measures over time,⁷⁵ particularly for individual physicians. As of this writing, Physician Compare publicly reports quality measures for group practices and ACOs. Individual physicians currently have biographical information (e.g., education) and green check marks indicating the federal quality programs in which they participate,⁷⁶ and approximately 175,000 individual physicians also have quality measures listed.⁷⁷

CMS has moved and is moving forward with posting quality measures for individual physicians, but has somewhat scaled back in terms of what data it plans to publish in the immediate future. CMS announced in the Calendar Year (CY) 2013 Physician Fee Schedule (PFS) Final Rule with Comment Period that it intended to publicly report on 2014 PQRS quality metrics for individual physicians, consistent with § 10331 of the ACA, as early as CY 2015.⁷⁸ Despite concerns, in the CY 2014 Physician Fee Schedule

⁷¹ See *About Physician Compare*, *supra* note 59.

⁷² In a Shared Savings ACO, providers are jointly accountable for the quality of care they provide and earn back from CMS some of the savings generated from providing higher-quality, lower-cost care. Jenny Gold, *Accountable Care Organizations, Explained*, KAISER HEALTH NEWS (Sept. 14, 2015), <http://khn.org/news/aco-accountable-care-organization-faq/>. Pioneer Program ACOs are high-performing health systems that can pocket more of the financial savings in return for taking on more financial risk. *Id.*

⁷³ *Quality Data and Physician Compare*, CMS.Gov, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/Quality-Data-and-Physician-Compare.html> (last updated Jun. 15, 2016) [hereinafter *Quality Data and Physician Compare*].

⁷⁴ See *infra* Section III.c. Physician Compare for group practice and individual physicians and other providers is available at: <https://www.medicare.gov/physiciancompare/>. Physician Compare for ACOs is available at: <https://www.medicare.gov/physiciancompare/aco/search.html>. (last updated Jun. 15, 2016).

⁷⁵ See *About Physician Compare*, *supra* note 59.

⁷⁶ See *Quality Data and Physician Compare*, *supra* note 73. Where available, the site lists the following for individual physicians and other providers: name; address; primary and secondary specialties; affiliation with a group practice; clinical training information; gender; languages spoken (other than English); hospital affiliation; American Board of Medical Specialties board certification information; whether physician accepts Medicare assignment; and indicator of satisfactory reporting under the PQRS Incentive Program, Electronic Prescribing Incentive Program, and Electronic Health Record Incentive Program. SYLVIA MATHEWS BURWELL, CMS PHYSICIAN COMPARE REPORT TO CONGRESS v-vi (2014), <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/Downloads/Physician-Compare-Report-to-Congress.pdf>.

⁷⁷ See *2015 Individual Clinician Measures: Publicly Reported on Physician Compare in December 2016*, CMS.Gov, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/Downloads/PC-2015-Clinician-Measures.pdf>.

⁷⁸ See 78 Fed. Reg. 43281, 43355 (July 19, 2013).

Final Rule, CMS planned to make available twenty 2013 individual PQRS measures collected through a registry, electronic health record (EHR), or claims if “technically feasible.”⁷⁹ However, CMS then decided to publish fewer measures, and from a different year, due to technical concerns and stakeholder feedback.⁸⁰ In December 2016, CMS expanded the number of quality measures publicly reported on Physician Compare for individuals, with data collected from claims and registry systems.⁸¹ Moving forward, CMS will continue to annually post green check marks for each quality program in which individual physicians participate.⁸² CMS plans to continue phasing in more measures for individual physicians and group practices.⁸³

Certain metrics will not be published on Physician Compare for individual physicians. CMS’ rationale for not including these measures, as well as analysis of CMS’ decisions regarding these measures, is discussed in Section III.A., below. The site will not include patient satisfaction scores for individual physicians, though these scores will be published for group practices.⁸⁴ Adverse actions, such as malpractice settlements, that are stored in the Data Bank will also be unavailable on Physician Compare for individual physicians.⁸⁵ Furthermore, the site will not include cost metrics.⁸⁶

2. Physician Engagement

Although the ACA requires CMS to consider stakeholder input when selecting quality measures for Physician Compare, CMS has struggled to develop strong engagement among stakeholders.⁸⁷ As a result, CMS has implemented a number of strategies to engage physicians and other healthcare entities in Physician Compare. For instance, the agency has solicited input from professional stakeholders, including healthcare providers and health systems, through rulemaking processes and outreach efforts, such as town halls, webinars, and panels.⁸⁸

However, physicians who do or will have quality data published on Physician Compare have limited options for input regarding their own data. As required under §10331(b) of the ACA, individual physicians have a 30-day preview period (though this may be

⁷⁹ 79 Fed. Reg. 67547, 67765 (Nov. 13, 2014) (citing 78 Fed. Reg. 74229, 74453-54) (Dec. 10, 2013)).

⁸⁰ See 79 Fed. Reg. 67547, 67773 (Nov. 13, 2014). Commenters raised concerns that the PQRS data that was supposed to be published was collected in 2013, when individual physicians did not know that the data was going to be collected and published in this manner.

⁸¹ See *2015 Individual Clinician Measures: Publicly Reported on Physician Compare in December*, *supra* note 77.

⁸² See 79 Fed. Reg. 67547, 67761 (Nov. 13, 2014).

⁸³ See 79 Fed. Reg. 67547, 67768 (Nov. 13, 2014).

⁸⁴ See *id.*; see also 79 Fed. Reg. 67772 (Nov. 13, 2014).

⁸⁵ See *About Physician Compare* *supra* note 59 (describing what will be published on the site).

⁸⁶ See *id.*

⁸⁷ See *About Physician Compare*, *supra* note 59 (“Section 10331(d) of the Affordable Care Act requires us to consider input from multi-stakeholder groups, consistent with sections 1890(b)(7) and 1890A of the Act, when selecting quality measures for Physician Compare.”).

⁸⁸ 79 Fed. Reg. 67547, 67761 (Nov. 13, 2014).

extended) to view quality data before it is published to Physician Compare.⁸⁹ Physicians can use the Physician Compare Lookup Tool to determine if they have performance scores available for preview and, if so, what their scores are.⁹⁰ However, there will not be an appeals process in which physicians could dispute the quality data that is published.⁹¹

The 30-day preview period does not apply to demographic data,⁹² but feedback from stakeholders about this limitation has had some effect. Physicians expressed concerns about inaccuracies in their demographic information, specialty, and hospital affiliation, which drove CMS to release steps for physicians to update their biographical data.⁹³ Now, physicians can submit updates to the Provider Enrollment, Chain, and Ownership System (PECOS), which is the underlying Medicare database that auto-populates the Physician Compare website with this information, or to contact CMS directly.⁹⁴ CMS has also updated the underlying PECOS database and incorporated Medicare claims data to verify professionals' demographic information; while there are still complaints about lags in updating, physicians have provided positive feedback on these changes.⁹⁵ Moving forward, the agency states that it is “continually working to improve [Physician Compare] and the administrative and demographic information included.”⁹⁶

3. Incentives to Participate

Physicians have no direct incentive to participate in Physician Compare because the data is pulled automatically from PQRS.⁹⁷ However, the introduction of financial penalties for failure to participate in PQRS, which began as a voluntary reporting system, has incentivized the participation of physicians and other entities.⁹⁸

There is some indication that the quality information published on Physician Compare, which is based on PQRS data, may soon be used to determine how much Medicare will reimburse individual physicians—a shift that could be of great importance to physicians. CMS already uses the PQRS data in its value-based purchasing program

⁸⁹ 78 Fed. Reg. 74229, 74447 (Dec. 10, 2013); *see also* CMS.Gov., *Guide to Physician Compare Preview Period*, https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/physician-compare-initiative/downloads/guide_to_physician_compare_preview_period.pdf (last visited Feb. 14, 2017).

⁹⁰ *See* CMS.Gov., *Guide to Physician Compare Preview Period*, https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/physician-compare-initiative/downloads/guide_to_physician_compare_preview_period.pdf (last visited Feb. 14, 2017).

⁹¹ *See Quality Data and Physician Compare*, *supra* note 73 (“[T]here will not be a formal appeals process. If measure data is collected and deemed suitable for public reporting, the data will be published on Physician Compare. All data will be published regardless of whether measure preview was confirmed.”).

⁹² 79 Fed. Reg. 67547, 67770 (Nov. 13, 2014).

⁹³ 78 Fed. Reg. 74229, 74447 (Dec. 10, 2013).

⁹⁴ *Id.*

⁹⁵ 79 Fed. Reg. 67547, 67761 (Nov. 13, 2014).

⁹⁶ 79 Fed. Reg. 67547, 67768 (Nov. 13, 2014).

⁹⁷ *See supra* Section II.C.1.

⁹⁸ *See About Physician Compare*, *supra* note 59.

to calculate the value modifier.⁹⁹ The value modifier “provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule (PFS) based upon the quality of care furnished compared to the cost of care during a performance period.”¹⁰⁰ The value modifier was originally only used for physician groups with at least 100 eligible professionals, but will be phased in over time, and is set to apply in 2018 to physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists who are solo practitioners and/or in groups of two or more eligible professionals.¹⁰¹ In its 2014 report to Congress, CMS stated that it is already attempting to align Physician Compare with the value modifier and implies that the data in Physician Compare could eventually be more tightly integrated into a value-based payment model for physicians.¹⁰²

4. Website Design

The Physician Compare website has already undergone a number of design iterations and will continue to evolve moving forward. Since the site’s initial launch, CMS has done a full redesign and improved the search functionality.¹⁰³

Additionally, benchmarking will not be used for individual physicians or group plans.¹⁰⁴ CMS was concerned that benchmarking would be difficult for consumers to understand; that arbitrary thresholds may magnify minor performance differences; and that the benchmark would be calculated inconsistently as compared to benchmarks CMS uses in other programs.¹⁰⁵

At the time the CY 2015 rule was finalized, CMS had also decided not to include any other type of system in which physicians would be ranked against one another.¹⁰⁶ Rather, the site displays performance rates visually, using a combination of numbers and five stars, with each star symbolizing twenty percent.¹⁰⁷

In an effort to avoid overwhelming and confusing consumers moving forward, CMS plans to include all measures in a downloadable file, but will not include all available

⁹⁹ See *Quality Reporting Road Map Design*, CMS.Gov, https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/PQRS/How_To_Get_Started.html (click on 2015 Beginner Reporting Toolkit).

¹⁰⁰ *Value-Based Payment Modifier*, CMS.Gov, <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram/valuebasedpaymentmodifier.html> (last updated Sept. 15, 2016).

¹⁰¹ See *id.*

¹⁰² See Sylvia Mathews Burwell, *CMS Physician Compare Report to Congress*, i, 19 (2014), <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/Downloads/Physician-Compare-Report-to-Congress.pdf>.

¹⁰³ 79 Fed. Reg. 67547, 67762 (Nov. 13, 2014).

¹⁰⁴ 79 Fed. Reg. 67547, 67774 (Nov. 13, 2014).

¹⁰⁵ 79 Fed. Reg. 67547, 67761 (Nov. 13, 2014).

¹⁰⁶ 79 Fed. Reg. 67547, 67776 (Nov. 13, 2014).

¹⁰⁷ See *id.*

data on the website itself.¹⁰⁸ CMS plans to do concept testing with consumers to see how well they understand each measure and which measures allow them to become more informed consumers.¹⁰⁹ Only measures that are understood by consumers and relevant to patients making informed decisions will be included in the website.¹¹⁰

CMS conducts an online survey of visitors to Physician Compare. On average, Physician Compare receives approximately 140,000 visits per month, with traffic spiking during open enrollment periods for Medicare beneficiaries.¹¹¹ On a five-point scale where 1 is “very hard” and 5 is “very easy,” approximately three-quarters of survey respondents rated the site 3 out of 5 for ease of finding information and website navigation.¹¹²

III. ANALYSIS OF PHYSICIAN COMPARE

A. Data

While CMS initially aimed to publish data from claims, registries, and EHRs,¹¹³ its strategy has been to publicly report only that data that is “technically feasible.”¹¹⁴ As a result, CMS first planned to publish scores for 2014 PQRS measures gathered only through claims, then expand later to data gathered through registries and EHRs,¹¹⁵ and now publishes data collected via claims and registries.¹¹⁶

This preliminary and continuing use of claims data combined with a relatively small minimum sample size of twenty patients¹¹⁷ may open CMS up to legal challenges, as was seen in New York in 2007. A number of major New York insurers developed individual physician quality reporting programs, and New York’s Office of the Attorney General issued letters to these insurance companies expressing concern about how they evaluated individual physicians.¹¹⁸ The Attorney General’s office eventually reached a settlement with the insurers by working with the insurers themselves, the American Medical Association, the Medical Society of the State of New York, and consumer advocacy groups.¹¹⁹ The settlement terms included changes to the way the insurers collected and utilized quality metrics for individual physicians.

¹⁰⁸ See *Physician Compare Datasets*, CMS.Gov, <https://data.medicare.gov/data/physician-compare> (last visited Feb. 27, 2017); 79 Fed. Reg. 67547, 67769 (Nov. 13, 2014).

¹⁰⁹ See *id.*

¹¹⁰ See *id.*

¹¹¹ Burwell, *supra* note 102, at 41.

¹¹² *Id.* at 42.

¹¹³ 78 Fed. Reg. 43281, 43355 (July 19, 2013).

¹¹⁴ 78 Fed. Reg. 74229, 74453 (Dec. 10, 2013).

¹¹⁵ See *supra* note 79; see also *About Physician Compare*, *supra* note 59.

¹¹⁶ See *2015 Individual Clinician Measures: Publicly Reported on Physician Compare in December*, *supra* note 77.

¹¹⁷ See Burwell, *supra* note 102, at 19.

¹¹⁸ See, e.g., Letter from Linda A. Laceywell, Counsel for Econ. & Soc. Justice, State of N.Y., Office of the Attorney Gen., to James E. Brown, Reg’l Gen. Counsel, Aetna (Aug. 16, 2007), <http://www.ag.ny.gov/sites/default/files/press-releases/archived/Aetna%20Final.pdf> [hereinafter, Aetna Letter].

¹¹⁹ See, e.g., Press Release, Attorney General of the State of New York, Agreement Concerning Physician Performance Measurement, Reporting, and Tiering Programs (Nov. 13, 2007), <http://www.>

For example, Aetna developed a physician-ranking program in which specialists were ranked by quality and those who met certain quality standards were included in-network; employers who selected the insurance plan with the physician-ranking program could offer incentives to their employees to use that network.¹²⁰ The Attorney General stated that the program carried “a significant risk of causing consumer confusion, if not deception.”¹²¹ The Attorney General was especially concerned that the use of claims data in ranking specialists would lead to an omission of clinically relevant information, creating a system that is “inaccurate,” “misleading,” and not transparent.¹²² The Attorney General’s particular concerns with the use of the claims data were: (1) claims data does not include relevant information that would be available through other sources, such as medical records; (2) the claims database is too small to create reliable rankings; (3) the sample size (per physician) may be too small to allow for meaningful results; and (4) many physicians may care for a patient during a clinical episode, so the quality metrics should not be unfairly attributed to just one physician.¹²³

The first critique is directly applicable to Physician Compare, in that claims data is inherently not comprehensive. The second critique may be less applicable to Physician Compare because a claims database on a national scale is much larger than that available to one insurer in one state. However, some commenters of the CMS Physician Compare plan echoed the Attorney General’s fourth concern that data would be inaccurately attributed.¹²⁴

As to the third concern, while not specific to claims data, commenters of the CMS plan have critiqued Physician Compare’s minimum sample size of 20 patients per physician¹²⁵ as too small. They are concerned a small sample size would not produce enough information at the individual physician level to develop accurate sample sizes and comparisons.¹²⁶ These concerns are grounded in real-world practice patterns, as individual physicians see only a few patients compared to the number of patients a hospital sees in the aggregate.¹²⁷ Consequently, scorecards for individual physicians may not be representative of the care individual physicians actually provide, in that a few patients could skew results.

On the other hand, the 20-patient sample size is similar to others in the quality reporting arena. This sample size matches that used as a reliability threshold for PQRS reporting¹²⁸

ag.ny.gov/sites/default/files/press-releases/archived/Aetna%20Life%20Insurance%20Company.pdf [hereinafter, Aetna Settlement].

¹²⁰ See Aetna Letter, *supra* note 118.

¹²¹ *Id.* at 1.

¹²² *Id.* at 2.

¹²³ See *id.*

¹²⁴ 78 Fed. Reg. 74229, 74453 (Dec. 10, 2013).

¹²⁵ 79 Fed. Reg. 67547, 67769 (Nov. 13, 2014).

¹²⁶ See *id.*

¹²⁷ See *id.*

¹²⁸ See 77 Fed. Reg. 68891, 69165 (Nov. 16, 2012); see also Burwell, *supra* note 102, at 19.

and is only ten patients fewer than the Joint Commission's required sample size of thirty for hospitals' National Quality Improvement Goals.¹²⁹

In response to commenters' concerns about the sample size and other issues, CMS stated:

We . . . believe strongly that individual-level measure data are important in helping consumers make informed healthcare decisions, and that this information should be posted on the site as soon as technically feasible We are committed to including only the most accurate, statistically reliable and valid quality of care measure data on Physician Compare when the data are publicly reported. Any data found to be invalid or inaccurate for any reason will not be publicly reported.¹³⁰

More specifically, CMS argued that the measures in question are already in use in the PQRS program and have already undergone significant review.¹³¹ CMS simply stated that it believes attribution of care will be accurate on the site.¹³² In future years, CMS will continue to make sure measures are appropriately selected and reported.¹³³ Only data that meets the accepted sample size will be reported, and CMS will evaluate language to explain to the public why all individual physicians do not have data published.¹³⁴

While CMS goals make sense, CMS still has room to learn from the important lessons arising from the New York insurance settlements before publishing data for individual physicians. CMS must be sure that the data is accurate, such that a few patients within the sample do not artificially inflate or deflate an individual physician's scores. The reasoning for picking the sample size and any methodology utilized to present data, including risk adjustment and attribution methods, must be both accurate and transparent to physicians. CMS must also ensure that the sample size adequately protects patient privacy. A small sample size may allow patients to be more easily identified by their distinctive characteristics. For example, within a small sample size, one variable (e.g. diagnosis, race, or gender) may be small enough to deduce the identity of that individual patient.¹³⁵

Precise methodology and transparency is important not just for data accuracy but also to prevent harming high-risk patients. Individual score cards in general, and Physician Compare in particular, have generated worries that physicians will cherry-pick patients in an effort to improve their scores. Commenters of the CMS plan for Physician Compare were especially worried that doctors may be incentivized to turn away patients who have

¹²⁹ See *Guidelines for Publishing Hospital NQIGs*, THE JOINT COMMISSION, http://www.jointcommission.org/accreditation/guidelines_for_publicizing_nqigs.aspx (last visited Nov. 23, 2015).

¹³⁰ 78 Fed. Reg. 74229, 74453 (Dec. 10, 2013).

¹³¹ See *id.*

¹³² See *id.*

¹³³ See *id.*

¹³⁴ See *id.*

¹³⁵ See Gregory Nelson, *Practical Implications of Sharing Data: A Primer on Data Privacy, Anonymization, and De-Identification*, SAS 1, 11 (2015), <http://support.sas.com/resources/papers/proceedings15/1884-2015.pdf>.

low health literacy, are poor, and/or are minorities often subject to healthcare inequities because these patients could lower the physicians' quality ratings.¹³⁶

This is a concern that has played out, to some extent, in New York's reporting system for mortality outcomes of cardiac surgeries, which publishes quality data for both hospitals and individual physicians by name.¹³⁷ Critics have contended that, as a result of the New York scorecards, higher-risk patients who need surgery are not receiving the intervention they need in New York.¹³⁸ Rather, the system forces these patients to go to another state for care.¹³⁹ In contrast, proponents of the New York system argue that it allows for identification of inferior practices and minimizes the performance of procedures that have an unjustifiably low chance of success.¹⁴⁰ They also contend that the scorecards have significantly reduced the risk of dying from cardiac bypass surgery¹⁴¹ and that hospitals with low-rated physicians have lost market share.¹⁴²

In response to concerns that physicians will choose not to treat high-risk and vulnerable patients, CMS argued that data collection at the hospital and group level has not led to cherry picking of patients, so there is no reason to believe it will cause individual physicians to turn away patients.¹⁴³ To further address concerns about potential cherry picking, CMS plans to evaluate risk adjustment methodologies to make sure that physicians with high-risk patient populations are not unduly penalized.¹⁴⁴ Risk adjustment is a statistical process that adjusts quality measurements by accounting for patients' characteristics that "may independently affect results of a given measure and are not randomly distributed across all physicians submitting quality measures."¹⁴⁵ These characteristics may include the type and severity of illness, patient demographics such as race and wealth, and insurance status.¹⁴⁶ Risk adjustment is intended to allow for

¹³⁶ See *id.*

¹³⁷ See New York State Department of Health, *Adult Cardiac Surgery in New York State: 2009-2011* (2014), https://www.health.ny.gov/statistics/diseases/cardiovascular/heart_disease/docs/20092011_adult_cardiac_surgery.pdf.

¹³⁸ See Todd Rosengart, *Understanding New York State's Reporting of Heart Surgery Data: When a List is Not a List*, ROSE BROOK SCH. OF MED. BLOG (Apr. 3, 2012), <http://medicine.stonybrookmedicine.edu/surgery/blog/understanding-new-york-states-reporting-of-heart-surgery-outcome-data>.

¹³⁹ See *id.*

¹⁴⁰ See *id.*

¹⁴¹ See Edward Hannan et al., *New York State's Cardiac Surgery Reporting System: Four Years Later*, 58 ANNALS OF THORACIC SURGERY 1852,1852 (1994), <http://www.ncbi.nlm.nih.gov/pubmed/7979781>; see also Daryl Hoffman, *Cardiac Surgery Reporting in N.Y. State: Is It Reliable?*, METRO (Apr. 28, 2013), <http://www.metro.us/lifestyle/cardiac-surgery-reporting-in-ny-state-is-it-reliable/tmWmdB—a3A95ayABGCU/>.

¹⁴² See David Dranove and Andrew Sfekas, *Start Spreading the News: A Structural Estimate of the Effects of New York Hospital Report Cards*, 27 J. HEALTH ECON. 1201,1201 (2008).

¹⁴³ 78 Fed. Reg. 74229, 74453 (Dec. 10, 2013).

¹⁴⁴ See *id.*

¹⁴⁵ Minn. Dep't of Health, *Minnesota Statewide Quality Reporting and Measurement System: Risk Adjustment of Physician Clinic Quality Measures*, 1, 2 (2011), <http://www.health.state.mn.us/healthreform/measurement/MDHRiskAdjustmentProposal.pdf>.

¹⁴⁶ See *id.*

a more fair comparison of patient outcomes across physicians by adjusting for patient factors beyond the control of physicians.¹⁴⁷

Although CMS has stated that it will implement risk adjustment as required under the ACA,¹⁴⁸ a risk adjustment formula is not clearly stated in the regulations. Rather, CMS generally says, “we will continue to analyze the measure data to ensure that risk adjustment concerns are taken into consideration,” then refers readers to a Technical Expert Panel website.¹⁴⁹

In setting a risk adjustment formula, CMS could again learn from the experience of the New York cardiac outcomes reporting system.¹⁵⁰ The system is risk adjusted, and the factors considered include age, the heart’s pumping capacity, and previous heart attacks.¹⁵¹ In certain situations, for example, the death of a high-risk patient may only count for half of mortality in the report.¹⁵² As a result, doctors should not experience decreased ratings for care provided to high-risk patients, thereby reducing the risk of doctors cherry-picking patients.¹⁵³ Some critics have argued, however that this system still promotes gaming,¹⁵⁴ perhaps because physicians do not understand or trust the risk adjustment formula.

In addition to concerns about cherry picking, CMS will also have to balance the benefits of including a robust risk adjustment formula with the potential for such an adjustment to deplete the quality data of meaning. On the positive side, CMS could foster physician buy-in by allowing physicians to have input regarding the risk adjustment formula. Risk adjustment could also allow for the data to more accurately reflect the care provided, in that higher risk patients would be given different weight than lower risk patients and not artificially deflate a physicians’ metrics. However, risk adjustment also introduces new variables that increase the difficulty of making the data transparent and accessible for both patients and physicians who are not well versed in risk adjustment methodology. Changing the formula each year also introduces the risk that comparing data across years could become an essentially meaningless exercise.

Analyzing what is not included in Physician Compare is just as important as analyzing what is included. CMS currently does not plan to publish patient satisfaction scores for individual physicians. Consumer Assessment of Healthcare Providers and Systems

¹⁴⁷ *See id.*

¹⁴⁸ Patient Protection and Affordable Care Act, *supra* note 46, at § 1395w.

¹⁴⁹ 79 Fed. Reg. 67547, 67765 (Nov. 14, 2014).

¹⁵⁰ 78 Fed. Reg. 74229, 74453 (Dec. 10, 2013).

¹⁵¹ David Dranove & Andrew Sfekas, *Start Spreading the News: A Structural Estimate of the Effects of New York Hospital Report Cards*, 27 J. HEALTH ECON. 1201,1201 (2008).

¹⁵² *Id.*

¹⁵³ Elisabeth Bumiller, *Death-Rate Rankings Shake New York Cardiac Surgeons*, N.Y. TIMES (Sept. 6, 1995), <http://www.nytimes.com/1995/09/06/nyregion/death-rate-rankings-shake-new-york-cardiac-surgeons.html?pagewanted=all>.

¹⁵⁴ *See supra* note 138 and accompanying text (noting concern that New York cardiac surgeons cherry-pick patients by treating low-risk patients themselves but sending high-risk patients to surgeons in other states for treatment).

(CAHPS) surveys ask patients about their satisfaction and experience with healthcare,¹⁵⁵ results of which will be published on Physician Compare for group practices.¹⁵⁶ However, CAHPS measures for individual physicians are not currently collected, so patient satisfaction data will not be published on the Physician Compare website.¹⁵⁷ Some commenters have expressed concerns that CAHPS surveys are too subjective and expensive to conduct.¹⁵⁸ Commenters are also concerned that certain CAHPS measures do not capture aspects of care, such as getting timely care, appointments, and access to specialists, all of which individual physicians do not control.¹⁵⁹ It is unclear if patient satisfaction metrics will ever to be included, and if so, how they will be developed.

Despite CMS' hesitance about publishing CAHPS patient satisfaction scores, the increased industry focus on "patient-centered care," has led to the publication of many surveys on patient satisfaction.¹⁶⁰ In addition to industry interest in quality, the publication of satisfaction scores for individual physicians on consumer sites such as HealthGrades.com and AngiesList.com may suggest that patients would like to see this type of data, and potentially would use patient satisfaction scores published on Physician Compare.

While consumer preference may incentivize the publication of patient satisfaction measures, there are also additional reasons not to publish this data regardless of the source. First, publication of patient satisfaction data may distract attention and resources from publishing accurate and understandable quality metrics.¹⁶¹ Second, consumers can ask friends and family members about their satisfaction with a particular physician in a way that is helpful for their decision-making without turning to a website. However, the average layperson does not have the ability to aggregate, analyze, and present the technical quality measures that would be available on Physician Compare.¹⁶²

At this point, it is not clear if patient satisfaction would be well received by patients or physicians. With so many survey options and pros and cons to consider, CMS should consider conducting additional research on whether patient satisfaction scores would be useful for patients and physicians. If so, CMS may then aim to determine the most effective methodology for gathering and presenting this data.

In addition to patient satisfaction scores, CMS also does not currently plan to publish any cost data on Physician Compare for individual physicians. A potential downside of

¹⁵⁵ See *About CAHPS*, AHRQ, <https://cahps.ahrq.gov/about-cahps/index.html> (last visited Nov. 23, 2015).

¹⁵⁶ See *Quality Data and Physician Compare*, *supra* note 73.

¹⁵⁷ See *id.*; see also 79 Fed. Reg. 67547, 67772 (Nov. 13, 2014).

¹⁵⁸ 79 Fed. Reg. 67547, 67772 (Nov. 13, 2014).

¹⁵⁹ See *id.*

¹⁶⁰ David A. Hanauer et al., *Public Awareness, Perception, and Use of Online Physician Rating Sites* (Research Letter), 311 JAMA 734, 734 (Feb. 2014) (discussing the publication of patient satisfaction surveys in Massachusetts and nationally on the Hospital Compare website).

¹⁶¹ See Kristin Madison, *The Law and Policy of Health Care Quality Reporting*, 31 Campbell L. Rev. 216, 231 (2009), <http://www.law.campbell.edu/lawreview/articles/31-2-215.pdf>.

¹⁶² See *id.*

publishing cost information is that “[c]onsumers may be encouraged to choose doctors because they are cheap rather than because they are good.”¹⁶³ It may also not be clear if the published data reflects the amount charged to the insurer or the out-of-pocket cost the patient would be responsible for paying. This lack of clarity could decrease any utility the cost data would have in helping patients make informed choices.

On the other hand, cost and quality are not always mutually exclusive, particularly in the new regulatory era of increasing both value and quality. Cost is important in many patients’ healthcare decisions¹⁶⁴ and high costs may lead to negative effects on patients’ mental and physical health.¹⁶⁵ When patients are ultimately financially responsible for their own care, some patients may seek out physicians who provide less expensive, but not higher quality, care.¹⁶⁶ Giving patients the data to make that choice in an informed manner is not necessarily a bad outcome.

One approach CMS could consider in publishing cost measures is that taken in the New York insurance settlement agreements, which established a new reporting system. The New York Attorney General and stakeholders agreed that cost could be published.¹⁶⁷ The cost information is an efficiency measure that takes into account what doctors charge for their services, as well as how many and what services they provide.¹⁶⁸ The published result is a comparison of expected to actual cost provided,¹⁶⁹ though it is not clear in the settlement or in Aetna’s materials whether this is the out-of-pocket cost to the consumer or the amount charged to the insurer. The quality metrics must be separated out from the cost measures, so that they are not mixed into a single metric.¹⁷⁰ If they are combined for a total ranking of physician performance, the insurer must disclose the weight given to both factors.¹⁷¹

While Physician Compare will publish biographical information, including board certification and education, it will not integrate the adverse actions housed in the Data Bank. Whether and how the Data Bank and Physician Compare could be integrated is a large enough topic for its own paper, and will not be addressed in-depth here, but the importance of the Data Bank information to the public seems to weigh in favor of

¹⁶³ Aetna Letter, *supra* note 118, at 3.

¹⁶⁴ See G. Caleb Alexander et. al., *Patient-Physician Communication About Out-of-Pocket Costs*, 290 HEALTH AFF. 953, 953 (Aug. 2003), <http://jama.jamanetwork.com/article.aspx?articleid=197137> (finding that 63% of patients would like to talk with their physicians about cost).

¹⁶⁵ See Thomas Richardson et. al., *The Relationship Between Personal Unsecured Debt and Mental and Physical Health*, 33 CLINICAL PSYCHOL. REV. 1148, 1154 (2013), <http://www.sciencedirect.com/science/article/pii/S0272735813001256> (“Overall the results suggest that unsecured debt increases the risk of poor health.”).

¹⁶⁶ See Madison, *supra* note 161 at 241, n. 123.

¹⁶⁷ See Aetna Settlement, *supra* note 119, at 4.

¹⁶⁸ See *What the Blue Star Means for You*, AETNA 1, 4 (2013), <http://www.aetna.com/docfind/pdf/aexcel-member-brochure.pdf>.

¹⁶⁹ See *id.*

¹⁷⁰ See *A Physician’s Guide to Aexcel*, AETNA (2014) 1, 7, <http://www.aetna.com/healthcareprofessionals/assets/documents/aexcel-physician-guide.pdf>.

¹⁷¹ See *id.*

moving toward integration of the two systems. Patients may not care whether a doctor is Board-certified,¹⁷² but citizens' successful efforts to have states publish Data Bank-like information on the state level¹⁷³ show that many patients would like to see information on adverse actions and decisions. States publish a patchwork of different reports and scorecards on this data, and a publicly available federal system would have the benefits of potentially reaching a larger audience and using one standardized methodology across the country. On the other hand, allowing states to continue to serve as laboratories for this type of information may help researchers isolate the impact and unintended consequences publication of this data could cause.¹⁷⁴

B. Physician Engagement

CMS has made extensive efforts to engage physicians and other professional stakeholders, through the rule making process, town halls, and other avenues.¹⁷⁵ Stakeholders are still concerned, however, that the processes used to publish data on Physician Compare are not yet transparent enough. For example, commenters have requested that CMS publish the results of validity and reliability studies.¹⁷⁶ In addition, Physician Compare will not include an appeals process.¹⁷⁷

Without increased efforts to engage physicians and other stakeholders or develop an appeals process, CMS may lose physician buy-in of Physician Compare. Again, CMS should consider the New York insurance settlement agreements in terms of increasing stakeholder buy-in and developing an appeals process. The agreements stress the importance of transparency, and that methodology should be fully disclosed.¹⁷⁸ The settlements also require the establishment of a "reasonable, prompt, and transparent" appeals process in which physicians "have the right to correct errors and seek review of data . . . and may submit any additional information, including that contained in medical charts, for consideration."¹⁷⁹

C. Incentives to Participate

There is no direct incentive to participate in Physician Compare. However, physicians, group practices, and ACOs are incentivized to participate in PQRS through negative payment adjustments if they do not report;¹⁸⁰ CMS then automatically pulls the data for

¹⁷² See Madison, *supra* note 161, at 229.

¹⁷³ See *supra* notes 37–42.

¹⁷⁴ See Madison, *supra* note 28, at 89.

¹⁷⁵ 79 Fed. Reg. 67,762 (Nov. 13, 2014).

¹⁷⁶ 79 Fed. Reg. 67,765.

¹⁷⁷ 79 Fed. Reg. 67,762.

¹⁷⁸ See Madison, *supra* note 161, at 245.

¹⁷⁹ See Aetna Settlement, *supra* note 119, at 8.

¹⁸⁰ See *Payment Adjustment Information*, CMS.Gov, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html> (last updated March 7, 2016) ("[I]ndividual [eligible professionals] and group practices receiving a negative payment adjustment in 2015 (based on participation in 2013) will be paid 1.5% less than the [Medicare Physician Fee Schedule] amount for that service. For 2016 (based on participation in 2014) and subsequent years, the negative payment adjustment is 2.0%.")

Physician Compare from PQRS.¹⁸¹ As noted above, health systems and physicians have some leeway in choosing which measures to report, for which patients.¹⁸²

This somewhat discretionary reporting system may lead to gaming, in that individual physicians or the entities through which they provide care (i.e. hospital administration) could only report PQRS measures on which physicians have done well, for the patients who have done well.¹⁸³ It could also lead to cherry picking patients, such that individual physicians only choose patients whom they believe will be “good” risks. These risks could materialize if physicians start to believe (whether accurately or not) that the scores on Physician Compare could negatively affect their business. This reaction could be particularly acute if physicians believe that the risk adjustment formula does not adequately correct artificially decreased quality ratings.

However, consolidation in the industry may offset the potential for gaming and cherry picking because health systems increasingly control how and what providers, particularly physicians, report. Hospitals and physicians are consolidating through employment arrangements and other structures to achieve the efficiencies of scale necessary to improve quality and meet other regulatory requirements.¹⁸⁴ Hospitals are increasingly purchasing or establishing other formal business relationships with physician practices, and moving from hiring physicians as independent contractors to full-time employees.¹⁸⁵ This is not a new trend,¹⁸⁶ but it is accelerating in response to the Affordable Care Act and other structural pressures for higher-quality, lower-cost care.¹⁸⁷ As a result of this consolidation, individual physicians, except those in independent practices, may have little control over which quality data is reported through PQRS and therefore have little opportunity to game the system and select only low-risk patients.

Although consolidation may decrease individual physician’s direct control over PQRS reporting, health systems should be expected to game the system on behalf of physicians. For example, if a majority of physicians, or even high-performing physician, receive bad scores on a certain measure, the health system may not report that measure the following year and may cherry-pick both the patients that it treats and the data that it reports in an attempt to artificially increase scores.

¹⁸¹ See *supra* notes 65–66.

¹⁸² See *supra* note 68–69.

¹⁸³ See *How to Get Started: 2016 PQRS*, *supra* note 67.

¹⁸⁴ See Paul Keckley, *A Fresh Look at Physician Employment By Hospitals*, NAVIGANT (July 27, 2015), <http://www.navigantrhp.com/a-fresh-look-at-physician-employment-by-hospitals/>.

¹⁸⁵ See *id.*

¹⁸⁶ See Kristin Madison, *Donabedian’s Legacy: The Future of Health Care Quality Law And Policy*, 10 IND. HEALTH L. REV. 325, 357–58 (2013), <https://www.northeastern.edu/law/pdfs/academics/madison-ihlreview-2013.pdf> (noting that physicians began leaving their solo and small practice for hospital employment in the 1990s).

¹⁸⁷ See, e.g., *Shared Saving Program*, CMS.Gov, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram> (last updated June 12, 2015) (noting that to be eligible for the Medicare Shared Savings Program, hospitals and physicians must form an Accountable Care Organization that provides high-quality care, from primary care to management of chronic conditions and emergency care, for Medicare beneficiaries).

PQRS data is also already used to calculate payments under the value-based purchasing program, and CMS seems to hint that Physician Compare could be used in the future to calculate value-based reimbursement for individual physicians in some way, or at least that Physician Compare and value-based purchasing could become more tightly linked.¹⁸⁸ Linking Physician Compare more tightly with the value modifier calculations may increase physician distrust of Physician Compare because Physician Compare could impact not only a physician's professional reputation, but also his or her compensation. On the other hand, entwining the two programs could provide an even greater incentive for physicians to provide high-quality care. If CMS decides to base payments on data published on Physician Compare, it must be sure that the data is accurate and that its methodology is as transparent as possible for physicians.

D. Website Design

Overall, both the presentation of information on the website and the ease with which Physician Compare can be found should be improved.

CMS states that it uses a combination of stars and numbers to present quality data on Physician Compare.¹⁸⁹ However, stars may not be the most effective means to convey information to patients. A 2015 study of how best to display physician quality data found that patients were most likely to understand quality measures through the display of an overall performance score and the use of colored dots and word icons.¹⁹⁰ While star ratings were more effective than bars and numbers only, stars were only the third-most effective rating system in terms of patient understanding.¹⁹¹

Although physicians are rated individually with the stars system, CMS has decided against comparing physicians to a benchmark or otherwise rating physicians against one another.¹⁹² Benchmarking, however, may provide meaningful advantages in improving quality, and CMS should more seriously consider including some sort of benchmarking or ranking system. For physicians, benchmarking can be effective in motivating engagement in quality improvement work and helping them compare their performance to others.¹⁹³ In addition, benchmarking “can help stimulate healthy competition”¹⁹⁴ among physicians. Physicians and CMS are already quite familiar with and spend a lot of time on benchmarking and rating in other CMS programs, such

¹⁸⁸ See *supra* note 99–102.

¹⁸⁹ See Burwell, *supra* note 102.

¹⁹⁰ See O.C. Damman et al, *Making Comparative Performance Information More Comprehensible: An Experimental Evaluation of the Impact of Formats on Consumer Understanding*, BMJ QUALITY AND SAFETY (epub ahead of print), <http://www.ncbi.nlm.nih.gov/pubmed/26543066>.

¹⁹¹ See *id.*

¹⁹² See *supra* note 104–05.

¹⁹³ *Practice Facilitation Handbook: Module 7 Measuring and Benchmarking Clinical Performance*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, <http://www.ahrq.gov/professional/prevention-chronic-care/improve/system/pfhandbook/mod7.html> (last updated May 2013).

¹⁹⁴ *Id.*

as the expenditures benchmark in the Medicare Shared Savings Program for ACOs¹⁹⁵ and the Medicare five-star quality rating that allows users to compare nursing homes to an average score.¹⁹⁶ CMS' expertise with benchmarking, as well as physicians' familiarity with these types of ratings, could translate to more effective development of benchmarking on Physician Compare.

In addition to what will and will not be included in the website design, it is also important to consider whether the site is relatively easy to both find and use. One caveat is that, as of this writing, Physician Compare only includes biographical data for individual physicians and quality scores for group practices and certain individual physicians.¹⁹⁷ ACO information is on a separate site, though the ACO site has Physician Compare in the name. So, the following discussion analyzes only what is currently available. However, the current iterations of Physician Compare and the ACO site may signal what CMS intends to do in terms of future design for the individual physician quality information. Therefore, this is still a useful inquiry.

CMS plans for both patients and physicians to use Physician Compare, with patients utilizing the quality information to make more informed healthcare choices and physicians responding to the quality information by improving the quality of care they provide.¹⁹⁸ Appealing to these two audiences presents a tough challenge for CMS. The agency will need to describe the quality measures in a way that satisfies physicians' requests for transparency and comprehensive descriptions of methodology, while still keeping the site simple enough to support patient comprehension. The healthcare industry entities that use the Data Bank information are steeped in medical malpractice litigation, so they most likely have a sense of what a malpractice settlement or adverse board action actually means, and would potentially find this information more useful than the average patient would if it were published on the site.¹⁹⁹ Similarly, practitioners will most likely have a deeper understanding than the average person of quality data published on Physician Compare. Further, physicians are clamoring for a more comprehensive presentation of information so they can be sure their data is accurate. In contrast, lay people may not be able to fully understand and effectively utilize detailed quality data.²⁰⁰ In short, the downside of a simpler website and data presentation runs the danger of attracting patients but obscuring the true complexity of the data, which could upset physicians and reduce buy-in.

Currently, the Physician Compare and ACO Compare sites skew toward complexity, though the design of the sites was not necessarily an intentional decision on the part

¹⁹⁵ See *Methodology for Determining Shared Savings and Losses under the Medicare Shared Savings Program*, CMS MEDICARE LEARNING NETWORK 3-6 (April 2014), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Methodology_Factsheet_ICN907405.pdf

¹⁹⁶ See *Five-Star Quality Rating System*, CMS.Gov, <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/fsqrs.html> (last updated Nov. 19, 2015).

¹⁹⁷ See *supra* notes 76–77.

¹⁹⁸ See 42 U.S.C. § 1395w-5 (2010).

¹⁹⁹ See Madison, *supra* note 28, at 88.

²⁰⁰ See *id.*

of CMS to improve accuracy or transparency. For example, the Compare websites for ACOs and group practices are completely separate, and it is difficult to navigate between them. The main Physician Compare website, where a user can find the group practice page and individual physician information that is currently available, does not include an obvious link to the ACO Compare website.²⁰¹ The author had to do an extensive Google search to find the ACO Compare website.²⁰² The challenge of finding the ACO Compare sites through a simple Google search²⁰³ may mean patients will not use the site.²⁰⁴ As ACOs move toward increasing levels of care coordination across health systems,²⁰⁵ ACO quality data is arguably as important as individual physician data, if not more so, for a patient seeking high quality care. CMS should consider strategies to streamline the sites. Currently, the individual physician biographies include a link to the physician's group affiliation(s) that brings patients to information on the affiliated group. CMS could consider doing the same for ACOs with which individual physicians are affiliated.

Despite CMS' efforts to improve usability,²⁰⁶ Physician Compare for group practices is still fairly unwieldy and the star system does not appear to be widely implemented. The group practices page does not indicate which practices are scored (with the star system or otherwise) and which are not. As a result, the user must randomly select practices and may not find any group practices that have quality scores. The author did not, in fact, find any group practices that had quality scores. Rather, in the field for quality programs on all of the group practices the author selected, no quality data was presented although there was a link to an outside website that describes the CMS quality programs. Similarly, the author was unable to find individual physicians with quality ratings on Physician Compare in searches by physician name, specialty, and location.

The difficulties of even finding the ACO Compare site, combined with the lack of clear quality data on the ACO Compare site and for group practices on the Physician Compare site, are issues CMS will need to address in future iteration for individual physicians if the data on individual physicians is going to be useful. It should also not be difficult for users to determine which physicians or practices have quality ratings and those ratings should be presented consistently across the sites.

²⁰¹ *Physician Compare*, MEDICARE.GOV (The link to the ACO Compare site is not listed with the other Medicare Compare websites on Physician Compare, which is where a user would expect to find the link. Rather, one must click on a link for "ACO quality data" under "additional information.").

²⁰² See *Accountable Care Organization (ACO) Quality Reporting*, CMS. Gov., <https://www.medicare.gov/physiciancompare/aco/search.html> (last visited Nov. 23, 2015). Note that once on the ACO site, the author selected a major Midwestern ACO (SSM Health ACO) and found that quality measures were presented as a percentage "performance rate," rather than with a stars or other pictorial system.

²⁰³ It is also fairly difficult, though less so, to find the Physician Compare site for group practices through Google.

²⁰⁴ See Hanauer, *supra* note 160, at 734.

²⁰⁵ See *Coordinating Your Care*, CMS.GOV., <https://www.medicare.gov/manage-your-health/coordinating-your-care/coordinating-your-care.html> (last visited Nov. 23, 2015).

²⁰⁶ 79 Fed. Reg. 67547, 67761 (Nov. 13, 2014).

In addition to making the site understandable for patients, CMS needs to encourage patients to find and use Physician Compare. As mentioned above, Physician Compare, particularly for ACOs, is currently hard to find and there does not appear to have been much dissemination to patients. Poor dissemination may limit patients' use of the sites, even if they would find the information useful.²⁰⁷ The possibility of supporting more patients in using the site and making informed healthcare decisions is still of value. To further reach patients, CMS should consider increasing outreach and marketing about the individual physician site, perhaps by working with health systems and physicians to provide information in their offices and during appointments. Physician Compare could also be more closely integrated with healthcare.gov so that patients could have the information on quality at their fingertips when choosing a health insurance plan. For example, a patient could see which physicians and ACOs she prefers based on quality scores, then choose a plan through which she could receive care from that physician and/or ACO.

CONCLUSION

Physician Compare has the potential to fulfill its dual goals of incentivizing physicians to provide higher-quality care and supporting patients in becoming more active, informed consumers. However, much work remains to be done. To maintain and grow physician engagement, CMS must also continue efforts to ensure that Physician Compare's quality measures are accurate and are published in a transparent, understandable way. Without increased dissemination and efforts to improve the clarity and usability of Physician Compare, patients will not be able to fully utilize the information on quality in choosing physicians.

²⁰⁷ See Dennis P. Scanlon et. al., *Are Healthcare Quality "Report Cards" Reaching Consumers? Awareness in the Chronically Ill Population*, 21 AM. J. MANAG. CARE 236, 243 (Mar. 2015), <http://www.ajmc.com/journals/issue/2015/2015-vol21-n3/are-healthcare-quality-report-cards-reaching-consumers-awareness-in-the-chronically-ill-population/P-3>. Note, however, that even with effective outreach, patients may choose not to use the site for other reasons. Id. (finding that patients may be satisfied with their existing provider and not motivated to "shop" for an alternative). Note that other reasons may also contribute to consumer choice not to use the sites. See Hanauer, *supra* note 160, at 734 (finding that patients may not use quality sites because their insurance limits their choice of provider and/or because they value the opinions of family and friends over websites in choosing a physician).