Physician Compare. The Affordable Care Act requires the federal government to post information about physician performance and quality of care on a public website. How’s it developing?

WHAT’S THE ISSUE?

Measuring physician performance and quality of care is a critical component of the move to greater accountability and improved value in health care. Surveys show consumers have high interest in information that helps them evaluate and choose physicians. Insurers, employers, and government are increasingly tracking physician performance—for quality improvement, network creation, contract negotiations, and payment incentive initiatives.

The federal government significantly enhanced its presence in this realm with the launch in 2010 of Physician Compare, a website mandated by the Affordable Care Act (ACA). Additionally, in April 2015 a new law—the Medicare Access and CHIP Reauthorization Act (MACRA)—altered the landscape of physician quality measurement and payment beginning in 2019. MACRA accelerates Medicare’s shift away from fee-for-service physician payment toward payment based on performance assessment, quality metrics, patient outcomes, and patient experience. As they take effect, many of those quality metrics will be added to Physician Compare.

This brief focuses on the rollout and evolution of Physician Compare to date and plans for the site in 2016 and beyond. An earlier version of this brief—pre-MACRA—was published in December 2014.

Physician Compare follows in the tradition of Hospital Compare, Nursing Home Compare, Home Health Compare, and Dialysis Facility Compare. Those earlier-established sites have evolved significantly over the past decade and now encompass thousands of facilities nationwide, including every acute care hospital in the nation and almost 16,000 nursing homes.

These sites are credited with advancing accountability and motivating improvements in care and quality. But they are also widely viewed as poorly organized, inadequately audited when data are submitted by facilities, and underused by consumers. As a result, the sites are not as useful and impactful as they could be.

Under the ACA and subsequent legislation, including MACRA, the Centers for Medicare and Medicaid Services (CMS) is required to make all the “compare” sites more consumer-friendly. For example, in April 2015 CMS began posting on Hospital Compare five-star ratings of hospitals based on eleven measures of patient experience, using the Consumer Assessment of Healthcare Providers and Sys-
Physician Compare is being updated amid these positive changes, and it also now has five-star ratings of a small number of physician groups.

WHAT’S THE BACKGROUND?

Efforts to measure, rate, and publicly report on physician performance and quality of care have proliferated in recent years. Better measures, methods, and technology have allowed for these “report cards.” But the demand from payers—employers, insurers, and government—for more accountability amid continued quality gaps and rising health care costs has been the main driver.

Most initiatives are state or regionally based, including the Robert Wood Johnson Foundation’s (RWJF’s) Aligning Forces for Quality initiative in nine states and seven cities and counties, sponsored by the RWJF from 2007 to 2015. Notably, nonprofit Consumer Reports partnered in 2012 with three of the Aligning Forces state-based efforts (Massachusetts, Minnesota, and Wisconsin) to create consumer-friendly ratings of physician groups.

RWJF also maintains a directory of 208 provider report card initiatives, which shows that there are now some fifty efforts under way to assess and report on physician performance. A handful are national in scope, such as the Society of Thoracic Surgeons initiative to provide performance information on the outcomes of coronary bypass surgery, the Health Care Incentives Improvement Institute’s searchable database of around 40,000 clinicians who have agreed to have their quality of care monitored, and the National Committee for Quality Assurance’s Recognized Clinician program.

In July 2015 ProPublica, an independent nonprofit news organization focused on investigative journalism, sparked controversy when it released ratings of 16,019 surgeons using Medicare data on surgery complication rates for eight procedures. ProPublica’s methodology came under intense fire and continues to be debated.

Rate-your-doc initiatives. Commercial ventures have garnered the most public attention. Some seventy companies invite consumers to rate and review their doctors online. They are creating cultural momentum around choosing physicians based in part on consumer reviews and other objective information, and not just a referral from a family member, friend, or other doctor. Modeled on other online product and service review sites, most earn money from advertising. Most prominent among them are: Healthgrades.com, RateMDs.com, ZocDoc.com, Vitals.com, and Yelp.com.

These sites come with a big caveat emptor: Many of the individual physician ratings are based on low numbers of reviews (usually fewer than ten), meaning the ratings for most doctors are far from statistically robust. And there is still debate on whether the ratings can be manipulated by doctors themselves despite the companies’ claims that they protect against this. Indeed, companies have sprung up that help doctors manage their ratings and reviews.

Consumer use. Research shows that consumers have trouble using the more complex provider ratings compared to the simpler commercial ventures’ ratings. By all accounts, a small proportion of consumers make use of physician ratings sites that present detailed quality metrics, such as Physician Compare and those sponsored by states, as well as those affiliated with the Aligning Forces communities. A Kaiser Family Foundation survey of 1,506 adults released in April 2015, for example, found that only 10 percent had seen any information on physician quality of care, and just 6 percent had used the information. That’s not surprising, because these initiatives are not widely marketed, and word of their existence has spread slowly. CMS declined to release specific numbers on consumer traffic to Physician Compare but acknowledged that it is low. However, doctors and health facilities do visit the site in relatively large numbers, CMS reports.

In contrast, the popularity of commercial online ratings is growing rapidly, abetted by advertising, marketing, and social media buzz. A survey of 2,137 adults conducted in 2012 and published in the Journal of the American Medical Association (JAMA) found that one in four people had consulted a commercial rating site when picking a primary care doctor that year. Sixty-five percent knew such sites existed, and 5 percent had rated a doctor online (see Exhibit 1). Healthgrades, believed
to be the largest physician review site, claims an average one million visitors a day, with that number growing 20–25 percent a year. A Web analytics firm puts the number at around six million unique visitors a month. Healthgrades says six million people have posted reviews of hospitals or doctors on its site as of September 2015.

Still, it is worth noting that only 19 percent of respondents in the JAMA survey said online ratings were “very important” when choosing a primary care physician—behind every other factor, including insurance acceptance (89 percent), convenient location (59 percent), years of experience (46 percent), and word of mouth from family and friends (38 percent).

**WHAT’S THE LAW?**

Physician Compare is mandated in section 10331(a) of the ACA. The law required CMS to develop a plan by January 1, 2013, to “make publicly available...information on physician performance that provides comparable information on quality and patient experience measures.” CMS released its initial three-year plan for the site in 2012. Updates have come annually since. Final plans for 2016 were still in process and open to comment as this brief went to press.

Thus, CMS has taken a stepwise approach to developing the site—as the law allows. It plans a gradual phase-in of performance measures along with incremental improvement to the site’s presentation and functionality. The site launched in beta form in late 2010 with nothing more than a directory of physicians and other providers that participate in Medicare. But after a slow start, the pace has accelerated.

In 2011 and 2012 CMS added to the site a database that identified clinicians participating in two Medicare-based quality reporting initiatives: the Physician Quality Reporting System (PQRS) and the Electronic Prescribing Incentive Program. Participation in these programs was also noted on the profile pages of individual doctors. In 2013 a database that identified the 350,000 physicians and other clinicians participating in Medicare’s electronic health record (EHR) incentive program (also called the meaningful-use program) was added to the mix. Doctors’ participation in that program was also noted on their individual profile pages.

The argument for making this information available is that physicians participating in such programs are more likely to be committed to transparency and improving the care they provide—a reasonable but as yet unproven assumption.

**Group practice data.** In 2014 CMS added 2013 performance data on diabetes and heart disease care for 139 group practices with twenty-five or more doctors or clinicians that serve Medicare patients and participate in the PQRS group practice reporting option. This includes many of the largest and best-known group practices, including Mayo Clinic facilities in Minnesota, Arizona, and Jacksonville, Florida; Cleveland Clinic in Ohio; Sutter Medical Foundation in California; and Henry Ford Health System in Michigan.

Also in 2014 CMS added to the site performance data for five measures of diabetes care and one measure of coronary artery disease care for 214 of the 360 accountable care organizations (ACOs) serving people enrolled in Medicare. About six million Medicare beneficiaries are now enrolled in an ACO.

Most importantly, starting in late 2015 CMS will post the first set of quality performance scores on physicians’ profile pages. The number of reported measures will then expand over time. Also, by the end of 2015, CMS says it will do the following:

### EXHIBIT 1

**Awareness and Use of Physician Ratings Online**

<table>
<thead>
<tr>
<th>Are you aware of physician ratings and reviews online?</th>
</tr>
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<tbody>
<tr>
<td>Yes — 65%</td>
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</table>

<table>
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<tr>
<th>If aware, have you sought ratings or reviews online?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once — 19%</td>
</tr>
<tr>
<td>More than once — 17%</td>
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</table>

<table>
<thead>
<tr>
<th>If you have sought ratings online, how useful have they been?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very useful — 41%</td>
</tr>
<tr>
<td>Somewhat useful — 52%</td>
</tr>
<tr>
<td>Not useful — 7%</td>
</tr>
</tbody>
</table>

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<tr>
<th>Have you or your family ever rated or written comments about a physician online?</th>
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</thead>
<tbody>
<tr>
<td>Yes — 5%</td>
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</table>

<table>
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<tr>
<th>If you or your family has ever rated a physician online, what type of rating did you give?</th>
</tr>
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<tbody>
<tr>
<td>Positive — 54%</td>
</tr>
<tr>
<td>Neutral — 29%</td>
</tr>
<tr>
<td>Negative — 19%</td>
</tr>
</tbody>
</table>

“Starting in late 2015 CMS will post the first set of quality performance scores on physicians’ profile pages.”

- Update many of the quality measures now available on the site with 2014 data;
- Post for the first time quality metrics associated with Million Hearts, a Department of Health and Human Services campaign to enhance heart disease prevention screening; and
- Post CAHPS measures for larger group practices for the first time, using 2014 data.

2016 and beyond. In 2016 CMS plans to extend the reporting of quality metrics to include groups of two or more physicians, containing CAHPS data as well. It also plans to add data from Medicare-qualified clinical data registries, update the Million Hearts data to include several other heart disease prevention measures, and expand the use of the five-star ratings scale to more and smaller physician groups.

CMS faces the (somewhat daunting) challenge in 2016 of figuring out how it will integrate all these disparate quality reporting and monitoring initiatives into one seamless program, as mandated by Congress in MACRA. MACRA also ups the ante on physician participation in Medicare performance measurement and incentive payment. The basics are these:

- By 2019 doctors who treat Medicare beneficiaries must choose between two options—enroll in a program called the merit-based incentive payment system or sign up to be part of an alternative payment model.
- The merit-based incentive payment system will adapt and combine multiple programs—PQRS, the EHR meaningful-use program, and the value-based payment modifier initiative—into one.
- Doctors opting for the merit-based incentive payment system must report quality-of-care measures to CMS. How is to be determined, but CMS likely will use an upgraded PQRS reporting system.
- Physicians will be scored on four components of care: quality (30 percent); resource use (30 percent); meaningful use of EHRs (25 percent); and practice improvement activities (15 percent).
- Physicians choosing the alternative payment model path would have to be part of an integrated health system, join an ACO, or turn their practice into an approved patient-centered medical home. They would be required to receive a “significant” portion of their revenue and income through mechanisms that base payment on performance and that involve financial risk. “Significant” revenue is defined as 25 percent of total Medicare revenue in 2018, increasing to 75 percent in 2022.

Clearly, the still-to-come rules surrounding this new quality reporting and payment system will affect what gets reported on Physician Compare. It also has the potential to enhance the importance of the site as consumers become aware of fundamental changes (in both the public and private sectors) in the way doctors are being assessed and paid.

WHAT’S THE DEBATE?

Under previous law and now MACRA, CMS faces the same obstacles as other entities in accurately measuring physician performance and reporting the results (to providers and consumers) in a compelling way: It’s simply not an easy thing to do. For starters, methods to adjust for illness severity (and other demographic parameters) of a doctor’s or group practice’s patients, while improving, are far from infallible. In addition, performance measures relevant to one medical specialty area—for example, general medicine or family practice—are not applicable to others. Lack of standardization also haunts the field. Meaningful comparisons are impossible if one doctor’s diabetes or asthma care, for example, is measured differently than another doctor’s care.

There is also the logistical challenge of aggregating billions of bits of data on the treatment of millions of people, verifying accuracy, and making sure measures are properly attributed to the correct physician or group.

Not surprisingly, front-line doctors remain skeptical of the whole process. Their trade groups argue that much physician performance measurement is still not scientifically ready for prime time and should not be used prematurely, for either consumer choice or payment programs. And, although they had a big hand in crafting MACRA, the American Medical Association (AMA) and other physician groups have pledged to pay close attention to the operational details CMS proposes. Sparks can be expected to fly.

19%

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Physician accountability and quality improvement advocates, meanwhile, complain that the field has been stuck for many years with too many measures of the processes of care and not actual patient outcomes. For example, it is important and relatively easy to measure how many patients in a group practice get a blood sugar test. More difficult but more meaningful is how many of that practice’s diabetes patients suffer, over time, the problems (such as blindness and heart disease) that result from poor blood sugar control. These advocate groups, too, have promised to monitor MACRA’s implementation carefully and push for meaningful outcome measures.

CMS’s challenge with Physician Compare is to be a fair arbiter in this ongoing debate even as the agency honors both the spirit and the letter of the ACA and MACRA. That may be a tough road. In an August 2014 comment letter to CMS in response to proposed Physician Compare plans for 2015 and beyond, the AMA said that it would “adamantly oppose the multiple proposals to extensively expand the Physician Compare website, as serious and fundamental flaws and errors remain unaddressed.”

As it builds Physician Compare, CMS faces other challenges:

Presentation. Packaging consumer review-based ratings of doctors for display online is relatively simple and has proved popular, as discussed above. Displaying the results of clinical measures is far more difficult, however. Health literacy and numeracy in the United States are low, even among the college-educated. Studies also show that many Americans are unaware of the extent to which quality of care varies among doctors. For example, many people tend to equate quality with price—that higher-price doctors and care will be better. When pressed in focus groups, however, consumers concur with expert opinion that being able to compare physicians’ performance on the results or outcomes of care would be meaningful.

Implementing outcome measures. Currently, progress in implementing outcome measures is slower than CMS and consumer and patient advocates want. The delay is attributable, in part, to the lack of standardization in the world of quality measurement and to the slower-than-expected rollout of fully operational and interconnected EHRs. That said, the big-data revolution is opening up new opportunities for extracting treatment results from large volumes of medical and insurance records, disease registries, Medicare claims, and all-payer claims databases.

Competing with consumer review sites. Consumer advocates are concerned that at the same time that government and nonprofit initiatives are slowly improving how they present clinical quality measures, consumer review sites are cornering the market. CMS has an opportunity to address that obstacle with Physician Compare if it quickly deploys patient experience measures, which are similar to but methodologically more sound than ad hoc patient reviews. CMS’s move to five-star ratings may also help. That said, consumers are very oriented to anecdotal narrative reviews, such as those posted on hundreds of product and service review sites. Permitting such reviews on Physician Compare’s individual physician profile pages would quite likely draw consumers in. Physician groups are resigned to consumer reviews on private sites but may oppose them on a government site.

Measuring individual doctors versus groups. Physician trade organizations and measurement experts argue that individual doctors should not be held accountable for care that is often delivered by teams or by a number of colleagues in a group practice or in collaboration with a hospital. That’s especially true as care becomes more coordinated in integrated health systems and ACOs.

But surveys show that consumers want information on individual doctors—to help them choose primary care doctors, specialists, and especially surgeons. At present, physician group practices are a focal point of measurement. Congress mandated in the ACA that Physician Compare present data on individual doctors, and CMS is committed to that goal, albeit under the constant watchful gaze of the AMA and others.

Gaining the public’s trust. Despite widespread antigovernment sentiment in parts of the country, the public’s trust in the data and information that the federal government presents on its many websites is fairly high. Experts don’t anticipate that consumers will question the data on Physician Compare if it is well explained and presented. There is concern, however, that physicians could undermine Physician Compare (and other efforts to measure physician performance) if they speak ill of it to patients.
Physician Compare is a work in progress. It has the potential to be an important source of information and empowerment for consumers and a significant driver of choice, competition, and health care improvement. CMS has learned much in recent years through its management of Hospital Compare and affiliated sites, and the launch of the insurance plan comparison site HealthCare.gov. But many obstacles remain. The posting of clinical quality and outcome measures will raise the stakes for physicians, and it’s not likely that there will be easy agreement on how Physician Compare should roll out in 2016 and beyond, perhaps especially as MACRA is implemented. Absent a significant upgrade in the site’s usability and aggressive marketing to make consumers aware of it, the site likely won’t reach a wide audience for years to come.

**Resources**


