ANNALS OF HEALTH LAW
Advance Directive

VOLUME 20 SPRING 2011 PAGES 86-96

Loss of Financial Incentives for Physician Quality Reporting: Insult to Injury or a Step in the Right Direction?

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I. INTRODUCTION

In 2009, newly elected President Barack Obama told the nation, "we know that our families, our economy, and our nation itself will not succeed in the 21st century if we continue to be held down by the weight of rapidly rising health care costs and a broken health care system." [1] These costs are staggering with 2.5 trillion dollars spent on healthcare in 2009, equating to nearly eighteen percent of the gross domestic product of the United States.[2] Proportional quality outcomes related to these expenditures are not consistently seen however, as one author noted "[i]t is hard to ignore that in 2006, the United States was number 1 in terms of health care spending per capita but ranked 39th for infant mortality, 43rd for adult female mortality, 42nd for adult male mortality, and 36th for life expectancy.**"** [3]

These cost and quality issues affect all Americans, including the forty three million who are provided for each year as beneficiaries under Medicare.[4] The Medical Payment Advisory Commission recognized in 2008 that funding to the Medicare program was in

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1. Barak Obama, President, *Two Pillars of a New Foundation* (May 16, 2009), *available at* http://www.realclearpolitics.com/articles/2009/05/16/two_pillars_of_a_new_foundation_96530.html.

2. *Nat'l Health Expenditures Fact Sheet*, U.S. DEP'T OF HEALTH & HUMAN SERV. CMS. https://www.cms.gov/pf/printpage.asp?ref=http://www.cms.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp (last visited Apr. 29, 2011)

3. Christopher J.L. Murray, et al., *Ranking 37th — Measuring the Performance of the U.S. Health Care System*, NEW ENGLAND JOURNAL OF MEDICINE, (Jan. 6, 2010), http://healthpolicyandreform.nejm.org/?p=2610.

4. *Medicare Coverage - General Information Overview*, U.S DEP'T OF HEALTH & HUMAN SERV. CMS http://www.cms.gov/CoverageGenInfo/ (last visited Feb. 14, 2011).

jeopardy and it is projected that the Medicare Part A Trust Fund will become insolvent by 2019.[5] In an effort to control costs, the Federal government has proposed cuts to physician and hospital funding for Medicare patients.[6] Though these proposed cuts have been close to passage in the legislature on several occasions, actual reductions were not implemented and the final decision on this issue has been postponed until late 2011.[7] In addition to the ongoing budget discussions, quality issues have also been reviewed, and in 2006, a quality reporting system was initiated through the Centers for Medicare and Medicaid Services (CMS).[8] Under the initial guidelines, reporting on quality data measures was voluntary.[9] In 2007, this changed to an incentive based program and participating physicians were paid a percentage return for reporting on quality measures for Medicare patients.[10] With the passage of the Patient Protection and Affordable Care Act (PPACA) in 2010, additional changes were made to the system of quality reporting.[11] Though reporting remains "voluntary," physician incentives have been replaced by a negative incentives program.[12] This means that beginning in 2011, physicians who choose not to report data for their Medicare patients will lose the prior incentives on a tapering schedule, and will also see a decrease in their Medicare reimbursement rates.[13] This article will explore the possible reactions to and outcomes of these newest changes in the setting of an already stressed Medicare system and the potential effect of these changes on quality and access to care for America's growing Medicare population.

It is estimated that the United States total population, as of 2010, was roughly 310 million, with a little over forty million Americans being more than sixty-five years old. [14] By 2020, there will be nearly fifty-five million people over the age of sixty-five and

5. *Report to the Congress: Reforming the Delivery System*, MED. PAYMENT ADVISORY COMM'N. (June 2008), *available at* www.medpac.gov/documents/jun08.; BARRY R. FURROW ET AL, HEALTH LAW: CASES, MATERIALS AND PROBLEMS 768 (6th ed. 2006).

6. *Payment Action Kit - Medicare News and Resources.* AM. MED. ASS'N. http://www.ama-assn.org (last visited Feb. 19, 2011).[hereinafter *Payment Action Kit*]

7. *Id.*

8. DEP'T. OF HEALTH AND HUMAN SERVS., - CMS. CMS MANUAL SYSTEM, TRANSMITTAL 35, (2005), *available at* https://www.cms.gov/transmittals/downloads/R35DEMO.pdf.

9. *Id.*

10. U.S DEP'T OF HEALTH & HUMAN SERV. – CMS, PHYSICIAN QUALITY REPORTING INITIATIVE - 2007 REPORTING EXPERIENCE, (Dec. 3, 2008) [hereinafter 2007 REPORTING EXPERIENCE].

11. Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148 § 3002 (2010)

12. *Id.* at (b)(8) (i-ii).

13. *Id.*

14. *U.S. Population Projections*, U.S. CENSUS BUREAU (Aug. 14, 2008), *available at* http://www.census.gov/population/www/projections/summarytables.html.

eligible for Medicare coverage.[15] The President's estimated Medicare budget for 2010 was 447 billion dollars.[16] In Executive Summary of their June 2008 report, the Medicare Payment Advisory Commission stated that "[w]ithout change, the Medicare program is fiscally unsustainable over the long term and is not designed to produce high-quality care."[17] One of the Obama administration's stated goals is "to fundamentally reform our health care system, delivering quality care to more Americans while reducing costs for all."[18] Charged with a portion of this task, CMS has stated that they are attempting to become a purchaser of high quality health care by linking payment to the value of care provided.[19] To that end, they have initiated measures to assess the quality of care delivered.

II. PRIOR VERSIONS OF PHYSICIAN REPORTING

The first reporting program rolled out in 2005 by CMS, was the Physician Voluntary Reporting Program.[20] The program invited physicians to report data and identify the most effective ways to use the data in practice, with a goal of improving the delivery of care.[21] Some critics felt that while well intentioned, the lack of financial incentive did not foster interest.[22] In addition, the cost versus benefit of participating in this program was a potential deterrent.[23] The Tax Relief and Health Care Act of 2006, signed into law by former President George W. Bush, included a new provision for reporting of data on quality measures by physicians.[24] This new system, which had a start date of July 2007, was different in that while still voluntary, the reporting was linked to incentive payments for physicians.[25] CMS termed this new system, including the incentive payment

15. *Id.*
16. Letter from Holly Stockdale, (May 20, 2009), *in* the CONG. RESEARCH SERV. REPORT FOR CONG. *available at* http://aging.senate.gov/crs/medicare4.pdf.
17. MED. PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: REFORMING THE DELIVERY SYSTEM, (2008), *available at* http://www.medpac.gov/documents/jun08_entirereport.pdf.
18. *A New Era of Responsibility: Renewing American Promise*, OFFICE OF MGMT. & BUDGET 1, 2 (2009) http://www.gpoaccess.gov/usbudget/fy10/pdf/fy10-newera.pdf
19. 2007 REPORTING EXPERIENCE, *supra* note 10 , at 22.
20. DEP'T. OF HEALTH AND HUMAN SERVS., *supra*, note 8 at 3.
21. *Id.*
22. Paul Stinson, *The PQRI catch-22: The CMS 1.5 percent reimbursement may incentivize IT adoption, but will it do so equally, and is it enough?* (Oct. 1, 2007)
23. *Id.*
24. 2007 REPORTING EXPERIENCE, *supra* note 10 , at 3.
25. *Id.* at 3,6.

structure, the Physician Quality Reporting Initiative (PQRI).[26] The new PQRI program, defined in the Tax Relief and Health Care Act, states that the physician who submits data on quality measures, as outlined in the CMS reporting system will, in addition to the amount otherwise paid, receive an additional amount equal to 1.5% of the allowed charges for all covered professional services.[27] To receive the additional payment, the physician must timely submit data selected from a list of seventy-four identified quality measures.[28] The list of reportable items includes a wide variety of high-volume disease and wellness categories over a broad reach of specialties including, for example, standard medication requirements for cardiac disease and stroke as well as the results of standard screening tools for cancer, cataracts, osteoporosis, diabetes and some childhood illnesses.[29] Data collection began in July 2007, and in the first six months, total incentive payments of $36,000,669 were made based on nearly 7.3 million valid quality data code submissions.[30]

CMS evaluated the first year of the program in a report in 2007 and concluded that while there were problems with the reporting mechanism itself, the program was successful "as more than half of all who participated in the program satisfied the statutory requirements for satisfactory reporting and thereby earned incentive payments." [31] In the final paragraph of the report, CMS was optimistic that participation would increase as the Medicare physician participation program had, and concluded that:

Medicare is rapidly transforming from a passive payer into an active purchaser of high-quality care by linking payment to the value of care provided. PQRI is an important first step toward establishing a value-based purchasing program for physicians. PQRI participation rates should increase over time, much like participation rates for the Medicare participating physician program, which began in 1984. . . . Initially, about 30 percent of physicians signed participation agreements, but the number increased to about

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26. *Id.* at 3.

27. *Analysis and Payments* CTRS. FOR MEDICARE AND MEDICAID SERVS., http://www.cms.gov/PQRI/25_AnalysisAndPayment.asp#Topof Page (last visited Mar. 3, 2011).

28. 2007 REPORTING EXPERIENCE., *Supra* note 10, at 3.

29. Ctrs. for Medicare and Medicaid Servs. 2007 PQRI Quality Measures, Measures List http://www.cms.gov/PQRI/37_2007_PQRI_Program.asp#TopOfPage; U.S DEP'T OF HEALTH & HUMAN SERV. – CMS, 2007 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) PHYSICIANS QUALITY MEASURES. (2007).

30. 2007 REPORTING EXPERIENCE, *supra* note 10, at 10.

31. 2007 Reporting Experience, *supra* note 10, at 17.

90 percent by the mid-1990s and was at 95 percent in 2007.[32]

The program continued into 2008 and 2009 after additions and corrections were made to the reporting system.[33] The incentive payment percentage remained 1.5 percent in 2008 and was increased to 2.0 percent in 2009.[34]

III. IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

In March 2010, the Patient Protection and Affordable Care Act (PPACA) was signed into law. [35] Section 3002 of PPACA amended the Social Security Act to make changes to the existing PQRI system.[36] First, the program of incentivizing physicians for participation at a 2% rate was given an end date of 2014.[37] Incentive payments will phase-out on a tapering basis such that the rate will be 1% in 2011 and 0.5% for 2012 through 2014.[38] Following this, beginning in 2015, the fee schedule amount for services will be equal to the "applicable percent" of the fee that would otherwise apply to such services.[39] This means that the rate of reimbursement for services provided, for those physicians who do not satisfactorily submit data on quality measures will be reduced.[40] In 2015, the rate of reimbursement will be 98.5% of the regular fee amount and in 2016 and subsequent years, 98%. [41]

In addition, § 3002 of the Act states that by January 1, 2012, a plan will be in place to integrate the reporting of quality measures with the use of electronic health records (EHR).[42] Physician practice groups were already incentivized to show evidence that the professional was a "meaningful EHR user".[43] The new § 3002 language calls for integration, which consists of selection of reporting measures that demonstrate meaningful use of the EHR and the quality of care furnished to an individual.[44]

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32. 2007 REPORTING EXPERIENCE, *supra* note 6, at 22.
33. 2007 REPORTING EXPERIENCE, *supra* note 10, at 3.
34. *Analysis and Payments*, CTRS. FOR MEDICARE AND MEDICAID SERVS., http://www.cms.gov/PQRI/25_AnalysisAndPayment.asp#Topof Page (last visited Mar. 3, 2011).
35. PPACA, Pub. L. No. 111-148 § 3002 (2010).
36. *Id.*
37. 42 U.S.C.A. § 1395w–4(m)(1)(A) (2010).
38. *Id.* at (m)(1)(B)(i-iv).
39. *Id.* at § 1395w-4(a)(8)(A)(i).
40. 42 U.S.C.A. § 1395w-4(a)(8)(A)(ii)(I-II).
41. 42 U.S.C.A. § 1395w-4(a)(8)(A)(ii)(I-II).
42. Patient Protection and Affordable Care Act. Pub L. No. 111-148 § 3002(d).
43. 42 U.S.C.A. § 1395w-4(o)(1)(A)(B).
44. Patient Protection and Affordable Care Act. Pub L. No.111- 148 § 3002(d).

IV. PPACA CHANGES CONTEXTUALIZED

2010 saw an ongoing debate in both the house and senate regarding proposals to cut funding for Medicare up to twenty-five percent based on some estimates.[45] After multiple votes over the course of the calendar year, in December, President Obama signed the Medicare and Medicaid Extenders Act, postponed the debate on this issue to 2011.[46] This complex issue is not the subject of this article, however, the effect of PRQI changes must be considered in the context of the Medicare debate, as PRQI further affects physician reimbursement. The discussion of cutting Medicare funding is not new and the prospect of cutting reimbursement has been discussed and then postponed, multiple times over the last ten years. [47] In addition, a concept called Medicare opt-out began with the passage of the Balanced Budget Act of 1997, which included a provision allowing physicians and beneficiaries to privately contract for Medicare-covered services when certain requirements were met.[48] The ability to contract privately, allowed for physicians "opt out" of the Medicare program.[49] In 1998, CMS (then the Health Care Financing Administration), noted that there were benefits to opting-out, including a decreased chance for Medicare fraud and knowledge on the part of the beneficiary as to whether the services they sought under Medicare would be covered.[50] By 2005, the number of physicians opting-out was reportedly small with one source noting that that "very few" providers found opting-out attractive and the departure of this small group of providers did not appear to have created access problems for beneficiaries.[51] In 2007 however, the American Medical Association (AMA) noted that due to potential decreases in funding, "[m]any physicians may want to reconsider their current Medicare participation arrangements" and included opting-out as one of the possible options for

45. *Payment Action Kit*, *supra* note 6.

46. *Id.*

47. Markian Hawryluk, *CMS sticks to 4.2% Medicare pay cut: Physicians wait for Congress to act after proposed rule offers no relief.* Aug. 25, 2003. http://www.ama-assn.org/amednews/2003/08/25/gvsa0825.htm ; Mary Ellen Schneider, *Medicare Proposes 5.1% Physician Pay Cut in 2007*, INTERNAL MEDICINE NEWS, PRACTICE TRENDS 59 (Sep. 1 2006). http://imn.gcnpublishing.com/fileadmin/content_pdf/imn/archive_pdf/vol39iss17/74148_main.pdf.

48. *Testimony on Private Contracting in Medicare Before the Senate Fin. Comm.*(1998) (statement of Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration).

49. *Id.*

50. *Id.*

51. William Buczko, *Provider Opt-Out Under Medicare Private Contracting*, HEALTH CARE FINANCING REV., /Winter 2004-2005, at 43.

change.[52] In 2009, a report of the Congressional Budget Office (CBO) found that a substantial reduction in payment rates could lead some physicians to stop accepting assignment of Medicare patients but also noted that it was difficult to evaluate the full extent of these reductions on access to care.[53] The report hypothesized that the reductions would affect physician participation variably by specialty with primary care physicians (PCPs) being the most likely to withdraw, as in many areas of the country, privately insured patients seek PCP services such as these physicians would not need to rely solely on Medicare as a source of reimbursement.[54] The CBO concluded that over time, the number of practicing PCPs would likely decrease. [55]

By 2011, The American Association of Physicians and Surgeons posted document examples, to facilitate Medicare opt-out including, "How to Opt Out of Medicare" and stated, "Thousands of physicians have already opted out."[56]

In February 2011, the House Ways and Means Committee heard testimony from CMS Administrator Dr. Donald Berwick, and Chief Actuary Richard Foster, regarding the impact of PPACA on senior citizens.[57] The Committee was dissatisfied with the answers of Dr. Berwick and was troubled by Mr. Foster's statement that "[i]f Medicare payment rates become lower than the current level for Medicaid, which would in fact happen over time under the Affordable Care Act, then it raises questions about the ability of beneficiaries to have access to care."[58] In a statement after the hearing, the Committee felt they had clear testimony from the CMS Administrator that "[S]eniors and other beneficiaries can expect higher costs and loss of access because of the Democrats' health care law." [59]

PRQI is inexorably linked to creation or maintenance of an electronic health record

52. *Payment Action Kit*, *supra* note 6; (last visited Mar. 30, 2011).

53. Letter from Douglas W. Elmendorf, Dir.**,** Cong. Budget Office to the Budget Comm. of the U.S. House of Representatives 1, 4 (Mar. 27, 2009).

54. *Id*. at 2.

55. *Id.*

56. *How to Opt Out of Medicare* ASS'N OF AM. PHYSICIANS & SURGEONS (Feb 1, 2011),http://www.aapsonline.org/medicare/optout.htm.

57. *See* Press Release, Committee on House Ways and Means, Medicare Chief Refuses to Answer Congressional Inquiries About the Health Care Laws' Impact on Seniors Would Not Change One Thing in the 2,200 Page Law, (Feb. 10, 2011), http://waysandmeans.house.gov/News/DocumentSingle.aspx?DocumentID=224603.

58. *Id.*

59. *Id.*

and § 3002 calls for an integration of quality reporting with EHR.[60] EHR has gained acceptance as a helpful and efficient method of keeping and culling data from the patient record, however, installation of such software can range from roughly $1,000.00 in a small practice to perhaps $15,000.00 in a larger group with considerable variation based upon the number of licensed users.[61] It is important to recall the statutory incentive program is in place to help defray costs in this area, but a survey by the Centers for Disease Control found that while approximately fifty percent of physician practices surveyed will be using EHR by 2010, only ten percent described use of fully functional systems. [62] To assist with the process, CMS published a document called PQRI Electronic Health Record Reporting Made Simple. [63] It is worthy of note however that in this document, the physician is counseled to "[c]ontact [their] EHR vendor to determine if [their] EHR system is qualified for use in PQRI EHR-based reporting." [64] The "qualified" language has sparked a market response to the EHR software need, such that a web-search for "[s]oftware installation, EHR" results in 180,000 hits.[65]

To add fuel to the fire for scrutinizing Medicare reimbursement, in early 2011, the Associated Press reported that 111 physicians, nurses, healthcare company owners and executives, and others had been charged with participating in Medicare fraud schemes involving more than $225 million in false billing, reportedly the largest healthcare fraud investigation ever in this county.[66] The allegations were widespread but included overcharging Medicare patients for procedures, which were unnecessary, or never completed at all.[67] It is into this tumultuous arena that the new PRQI changes have been brought.

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60. Patient Protection and Affordable Care Act. Pub. Law No. 111-148, at § 3002(d)(7).

61. EQUALITY HEALTHCARE INFORMATION FOR PHYSICIANS, http://eqhip.com/index.cfm/pageid/13 (last visited Fed. 11, 2011) ; Unicharts EMR, http://www.unicharts.com (last visited Feb. 21, 2011).

62. Chun-Ju Hsiao et al., Ctrs. For Disease Control and Prevention, Electronic Medical Record/Electronic Health Record Systems of Office-based Physicians: United States, 2009 and Preliminary 2010 State Estimates (Dec. 2010) *available at* http://www.cdc.gov/nchs/data/hestat/emr_ehr_09.

63. *2010 PQRI Electronic Health Record (EHR) Reporting Made Simple*, CTRS. FOR MEDICARE AND MEDICAID SERVS, Jan. 2010, *available at* https://www.cms.gov/PQRI/Downloads/2010EHRPQRIMadeSimpleFS032310f.pdf.

64. *Id.*

65. GOOGLE, http://www.google.com (last visited Feb. 11, 2011).

66. Kelly Kennedy, *111 charged in Medicare scams worth $225 million: A massive crackdown on Medicare fraud rounded up more suspects than any in history*, ASSOCIATED PRESS, Feb. 17, 2011, *available at* http://www.salon.com/news/healthcare_reform/?story=/news/2011/02/17/us_medicare_fraud_bust.

67. *Id.*

V. POSSIBLE EFFECT OF THE PPACA PHYSICIAN QUALITY REPORTING CHANGES

Given the current tenor of the healthcare debate in this county, the effect of the changes to the PQRI requirements and incentives may be perceived by physicians as another item on a list of wrongs under Medicare reform. For physicians, the last ten years have seen, among others, pending cuts to Medicare funding overall, loss of financial incentive and now decreased reimbursement for non-participation. From the perspective of the government, the PQRI changes may be seen as CMS taking logical action to become the "active purchaser of high-quality care" they had hoped to become as of 2007. Since 2005, the government has made a significant financial investment in the PQRI system including financial assistance for implementation of the EHR, four years of incentive payments and education while physician practices learned the PQRI system. Both sides may see the loss of incentive payments as being insignificant as in 2007, CMS reported the average payout to physicians was approximately $635.00 per individual provider and the mean payout for group providers was $4,713.00.[68]

IV. EFFECT OF THE PQRI CHANGES ON ACCESS TO CARE

The issue then becomes whether the changes in the PRQI will be the last-straw for physician practices and lead to a decrease in the number of Medicare patients physicians are willing to see. The answer may turn on whether the reporting actually improves the quality of care doctors can deliver to their patients. The pooling of the PQRI patient data can be likened to a disease registry, through which physicians are able to track their patients individually or by population, such that they can provide proactive care and treatment to individual patients or groups of similar patients.[69] The concept of pooling data to improve care is established and registries have been described as crucial in the management of patients with chronic diseases.[70] This is consistent with the goals of the PQRI program as the AMA reports that, after sorting of the data by CMS, PQRI results allow physicians to complete their own performance improvement activities.[71] Other

68. 2007 REPORTING EXPERIENCE, *supra* note 10, at 10.

69. IA DEP'T OF PUB. HEALTH, DISEASE REGISTRY ISSUE BRIEF, (Apr. 2010), http://www.idph.state.ia.us/hcr_committees/common/pdf/prevention_chronic_care_mgmt/043010_executive_summary_draft.pdf.

70. *Id.*

71. *The AMA Practice Management Center. Physician Quality Reporting Initiative measured against AMA's Principles for Pay for Performance programs,* AMERICAN MEDICAL ASSOCIATION, Aug. 2008,

entities report that "PQRI is currently designed to encourage medical care providers to discuss quality care oriented questions during an office visit, as well as to encourage appropriate documentation of data in a patient's medical chart for follow up or reference at a later date and time. Reporting the requested data for PQRI incentive promotes awareness by providers and practices what data may or may not be fully or appropriately documented during their current patient process." [72] However, the Medical Group Management Association completed a survey regarding physician responses to PQRI in 2010.[73] This survey found continued dissatisfaction with accessing and use of feedback reports.[74] The survey included quotes from unidentified physicians with the negative responses clearly outweighing the positive. [75] One commenter felt that the process was working as "A couple of the measures for which we are reporting have actually proven to highlight areas where our physicians do need to pay attention to some clinical details."[76] Another however said "PQRI is a joke it has nothing to do with quality. Furthermore the reporting and feedback has been horrendous. . ." and a third "The PQRI is more trouble than it's worth but if penalties are put in effect we will have to participate." [77]

IV. CONCLUSION

CMS began to pave the path to this end in 2005 with the initiation of voluntary reporting. The incentivized reporting peaked interest and showed that it was possible for physician practices to participate in the PQRI data collection. The incentives for both PQRI and the installation of EHR facilitated participation. Participation in PQRI may be a good step for physician groups to take now, as it could be the basis for pay-for-performance programs of the future.[78] The setting is tumultuous and the end-of-the-day question is whether the structure, payments, data collection and involvement of the Federal government will result in higher quality, less expensive care for patients or will

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http://www.ama-assn.org/resources/doc/psa/CMS_pqri_chart.pdf

72. DocSite PQRI 2010 Frequently Asked Questions, COVISINT, DOCSITE PQRI http://www.docsite.com/products/pqri (last visited Apr. 30, 2011).

73. Press Release, MED. GRP. MGMT. ASS'N , Medical Practices Express Continued Frustration with PQRI Program. (Feb. 17, 2010), *available at* http://www.mgma.com/press/default.aspx?id=32798.

74. *Id.*

75. *Id.*

76. MED. GRP. MGMT. ASS'N, PHYSICIAN QUALITY REPORTING INITIATIVE LEARN 2010 MEMBER COMMENTS, (2010), *available at* http://www.mgma.com/WorkArea/DownloadAsset.aspx?id=32797

77. *Id.*

78. Mary Ellen Schneider, *Medicare's PQRI Could be the Basis of Future P4P*, INTERNAL MEDICINE NEWS, PRACTICE TRENDS 50, (Apr. 15, 2010), *available at*

these measures drive already discouraged physicians away from Medicare beneficiaries. There may be enormous implications for the access to care, especially for seniors, as these events play out over the next several years.

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http://imn.gcnpublishing.com/fileadmin/content_pdf/imn/archive_pdf/vol43iss7/70397_main.pdf.