Medicare's Physician Quality Reporting Initiative: Incentives, Physician Work, and Perceived Impact on Patient Care

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Purpose: The aims of this study were to compare incremental radiologist work to incremental financial incentives under Medicare's Physician Quality Reporting Initiative (PQRI) and to evaluate physicians' perceptions of the program's impact on the quality of care.

Methods: Medicare PQRI bonus information was acquired for 29 radiologists from a single practice over the program's first two cycles. Incremental bonus incentive percentages were calculated using total payments from Medicare and from all payers. Physicians were surveyed regarding incremental time required to participate and their perceptions of the program's impact on the quality of delivered care. Incentive data and survey results were analyzed and compared.

Results: Despite ongoing educational and operational initiatives, mean physician Medicare PQRI incentives amounted to only 0.36% of total practice Medicare payment, well under Medicare's expected bonus of 1.5%. As a percentage of collections from all payers, PQRI bonuses amounted to just 0.11%, well less than the estimated 1.5% mean increase in overall physician work necessary for participation. Only 10 (34%) and 6 (21%) radiologists received bonuses each cycle, respectively, and only 1 (3%) achieved bonuses for both cycles. Most physicians (76%) perceived that PQRI participation in no way improved the quality of radiologic services delivered.

Conclusion: Even when aggressively pursued, Medicare's pay-for-performance program, PQRI, yields actual physician bonuses far less than those expected, more than an order of magnitude less than requisite incremental radiologist work, with little reported impact on quality. For such programs to engender ongoing physician participation, fundamental changes will be necessary to address discordantly low incentives and perceived lack of benefit to patient care.

Key Words: Medical economics, radiology and radiologists, socioeconomic issues, pay for performance, physician incentives, quality and safety, metrics

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INTRODUCTION

Increasing health care costs, without demonstrable increases in quality, have led many policymakers to advocate pay for performance (P4P) and other forms of value-based purchasing. In concept, linking patient outcomes to provider and facility reimbursement encourages market-driven quality initiatives, but fundamental health care delivery system obstacles have inhibited the widespread implementation of such incentives.

To date, few private payers have formally adopted P4P programs. The Centers for Medicare & Medicaid Services (CMS) has undertaken the most visible initiatives, embarking on pilot plans for both hospitals and providers. The latter, Medicare's Physician Quality Reporting Initiative (PQRI), ostensibly encourages improved patient care [1] but has been criticized for rewarding physician and practice conformance with rigid documentation, reporting, and coding requirements [2-4].

Anecdotally, many physicians have reported PQRI participation to be time consuming and clinically non-

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productive, and practice managers have indicated that incentive payments have been disproportionately small compared with the administrative burden associated with participation, particularly since payment is now binary (ie, a physician either achieves a full bonus per period or receives nothing at all). Recently, one group reported that the administrative costs of participation often exceed incentive bonuses [5], but to our knowledge, no investigators have compared actual incremental payment with incremental physician work or evaluated the impact of PQRI participation on the quality of radiologist services. We report herein the initial two-cycle experience of a single large radiology practice that aggressively pursued PQRI participation through parallel operational and physician educational initiatives.

MATERIALS AND METHODS

All data were collected for and from Mid-South Imaging and Therapeutics, a large subspecialized radiology practice in Memphis, Tennessee, affiliated with a large regional hospital system and a referral teaching hospital. Shortly after CMS announced its plans to implement PQRI, the group's leadership initiated a series of plans to participate.

Already committed to ongoing physician compliance and billing education, the practice added several educational sessions at its monthly group meetings to prepare radiologists for PQRI, outlining strategies for documentation, including the use of report macros, as has been previously advocated [2]. This physician education was coordinated with the group's practice administrator, coding and billing staff, and compliance committee to streamline the subsequent administrative steps necessary to fulfill Medicare's numerous requirements for PQRI participation. We served as primary resource contacts for both physicians and staff for ongoing questions, educational clarification, and operational issues.

At the time the practice embarked upon PQRI participation, the leadership expected that its economic and noneconomic (eg, physician time) startup costs would likely exceed initial returns. Nonetheless, in anticipation of future, more robust (but hopefully more lucrative) programs, the practice aggressively pursued P4P at this early stage to advance the participatory learning curve of both physicians and staff members in developing a culture of reporting compliance and an appropriately supportive infrastructure.

Physician Participation

Although 37 physicians were employed by the group during at least some portions of the two PQRI periods assessed, only full-time physicians employed throughout both PQRI cycles were subject to evaluation for the purposes of this project. Anticipating a physician learning curve in meeting the program's very rigid documentation requirements, our intent was to report a "best practice model" of PQRI implementation. Accordingly, data collection and analysis were restricted to only the 29 radiologists who were available for the entirety of both cycles to benefit from all of the practice's educational efforts, from initial program orientation through ongoing training.

Financial Data Collection

The specific details of the PQRI program, including bonus incentive award methodology, extensive documentation requirements, and detailed reporting criteria, are all publicly available from CMS in numerous documents on its PQRI Web site [6].

PQRI incentive data were captured for both completed program cycles since the initiative's inception in 2007. The first CMS program period lasted only 6 months, from July 1, 2007, through December 31, 2007. The second program period included all 12 months of 2008. Because CMS does not award PQRI physician bonus incentives or release detailed incentive data until nearly a year after the conclusion of a cycle, 2009 data were neither captured nor analyzed.

Although Medicare incentive bonuses for achieving PQRI goals have since increased to 2.0% for 2009 and 2010, for the 2007 and 2008 cycles analyzed, maximum bonuses were only 1.5% of total Medicare payment per physician. As such, 1.5% was established as the maximum overall practice target incentive for this analysis.

Detailed incentive award reports were acquired from CMS for each participating physician and analyzed to extract bonus payments for each of the two reporting periods. Practice revenue cycle management software systems typically report revenue collected per reporting period. Because of processing delays, this does not exactly match actual services rendered during those specific time periods. Because PQRI incentives are calculated by CMS on the basis of the latter, not the former, the practice's accounts receivable database was reconstructed to extract both Medicare and non-Medicare claims per physician for services provided during each PQRI period.

Physician Survey

After the completion of the second PQRI cycle, but before full 2-cycle Medicare incentive reports were available for physician review, radiologists were asked to respond to 2 survey questions (Table 1) regarding their PQRI participation experience.

For question 1, physicians were encouraged to respond in an open-ended percentage fashion (ie, no cate-