Pay-for-Performance and Radiology Benefit Management: Insights from the Frontline

CareCore National
Donald R. Ryan, President and CEO

Radiology Management with Measurable Results

CareCore National Business Model

Payor

Referring Physician

C C N

Rendering Physician

Radiology Benefit Management: A Natural Fit for P4P

- Process oriented P4P programs link measurements of quality with incentive payments/penalties to influence providers' behavior.
- The CareCore National approach to P4P is driven by the unique characteristics of diagnostic imaging services.
- Imaging services lend themselves well to P4P:
  - » The structure of the delivery entity
  - » The ability to monitor the performance on a prospective and retrospective basis
  - » A meaningful scoring system
  - » Limited interdependencies among providers
  - » The ability to reassess the P4P criteria on a macro and micro level
  - » Strong support from payors

CareCore National's Quality Imaging Index (QII) program

- Established in 2002 to monitor and reward high-performing radiology practices
- Indicators developed in conjunction with practicing radiologists
- Three health plans participate in QII
- Ongoing evaluation of P4P performance standards
- Incentive:
  - » Practices receive payment based on a tiered payment methodology
  - » Health plan "set-asides" to enhance payments to participating facilities range from 10%-20%, and vary by health plan/payor
  - » Maximum add-on payment to individual participating provider ranges between 11% and 30%, depending on the health plan
  - » Payments made monthly, and vary based on performance tier
  - » Quarterly measurements
  - » Failure to pass image quality review results in full loss of P4P for the measurement period or until acceptable corrective action plan is implemented whichever is greater

CareCore National's Quality Imaging Index (QII) program
12 Performance Categories

CareCore National QII

Patient Satisfaction

- Scheduling standards
- 92% of patient surveys rating "very satisfied"
- Extended hours of operation

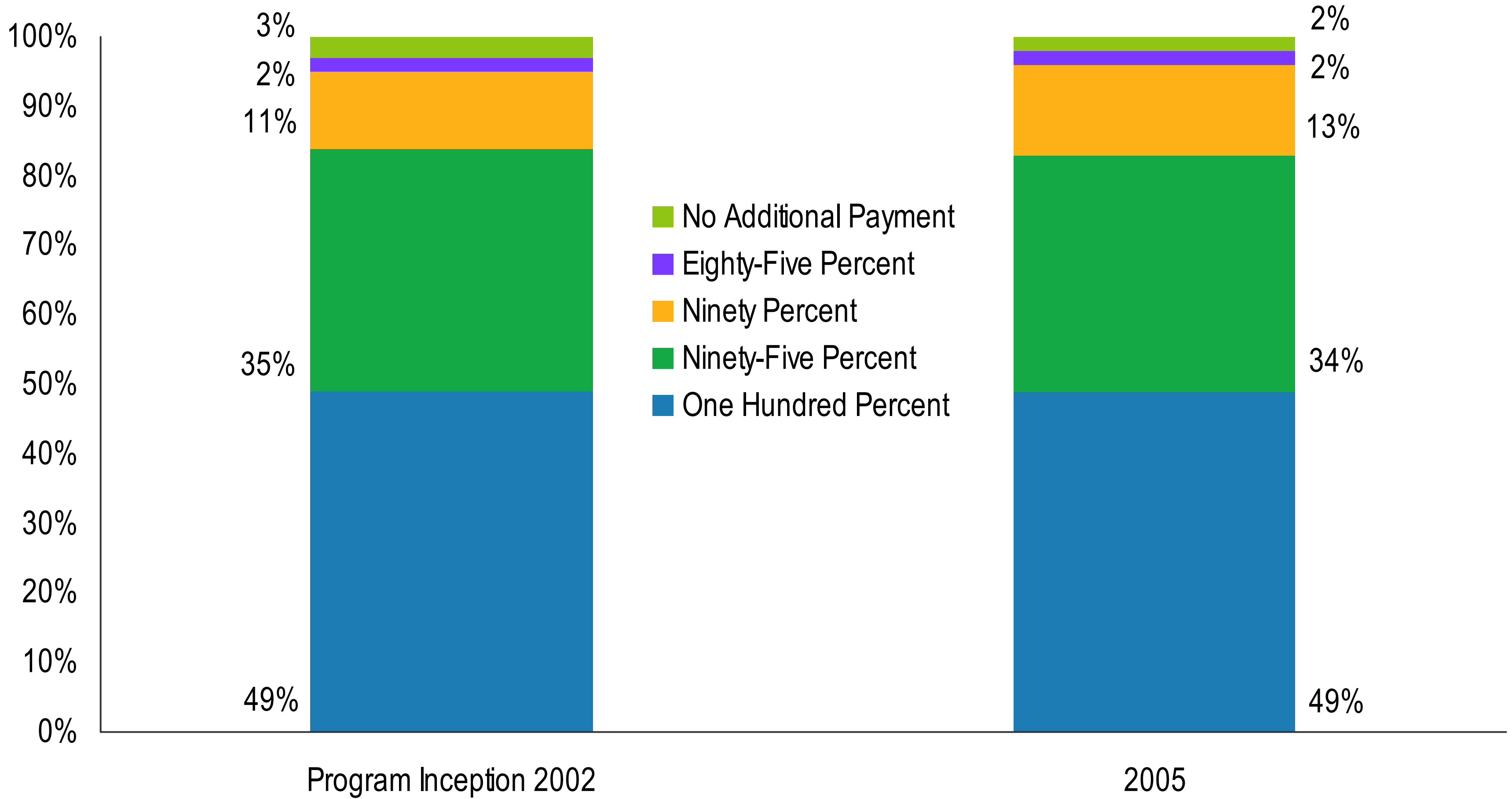
Clinical Standards

- Randomized film reviews:
  - ★ Image Quality
  - ★ Professional Interpretation
- Facility assessment
- 2 day report turnaround
- Staffing by board certified radiologist for at least 7 hours per day
- BI-RADS compliance
- Minimum % of radiologists have subspecialty fellowship training
- Accreditation of specific services

Cost Effectiveness

- Performance of multiple modalities/UM review
- Use of EDI data interface

Program Scoring – Incentive Levels



QII Results

Network Management:

- CareCore manages network participation. A number of new practices apply quarterly. The selection process is based on geographic need. All applicants must also meet stringent participation criteria for both professional and technical components.

Incentive Program:

- 2004 total paid claims without QII amounted to $109 million to three plans' participating providers
- 2004 QII payments added an additional $9.2 million in payments to three plans' participating providers
- Aggregate QII payments were 9% of the payments made in 2004
- Individual provider payment add-ons range from 0% to 30%, depending on health plan limit and provider performance

BI-RADS Compliance: One Element of CareCore's QII

- BI-RADS - Breast Imaging Reporting and Data System
- CareCore found widespread variation in the quality of reports and terminology used to describe findings of breast imaging examinations.
- The American College of Radiology developed the Breast Imaging Reporting and Data System (BI-RADS) to standardize the findings of breast imaging examinations and improve the quality of care delivered.
- CareCore adopted ACR's BI-RADS metrics into QII in the fall of 2004.
- To measure compliance, CareCore conducted an audit of eligible practices in 2004 by requesting 3 *non-random* examples of reports for each breast imaging modality.
    - » Compliance was judged by assessing the completeness and accuracy of 8 elements of demographic information and 4 elements of clinical information.

BI-RADS Results

- Initial findings and results were shared with participating providers, similar to initial roll-out of QII
  - » Providers were invited to re-submit examples that demonstrate corrective action plans
  - » Not all providers chose to re-submit; 7 improved their scores.
- 63% of practices were awarded QII points for compliance with all modalities (mammography, MRI, ultrasound).
- The overall quality of the reports was better than expected, but there were significant common deficiencies, including:
  - » Absence of a clear statement of the indication for the examination
  - » Description of the breast composition, shape and margins of the lesion, or nature of the enhancement for MRI reports
  - » Use of terms not in the BI-RADS lexicon

Lessons Learned from BI-RADS

- Appeals process is necessary for acceptance and participation
  - » In the BI-RADS review, 7 sites initially failed and were passed after reconsideration
- A number of “failing” practices did not submit corrective action plans.
  - » Likely attributable to limited impact on QII scoring/payment levels.
  - » Need to understand better why practices are not fully responsive
- “Soft launch” on non-random basis with the opportunity to correct deficiencies improved provider acceptance and provider “buy-in
- May consider subsequent conversion to a randomized approach with higher weights

Lessons Learned from QII

- Initial rollout generated substantial behavioral changes
  - » Facilities received preliminary scoring prior to live date. Participants given chance to increase scores prior to live date.
- Limited year-to-year improvement in scores
  - » CCN program is now designed to continually enhance the quality and scope of the performance measures.
- QII payments based on absolute scores may not generate continuous improvement
- Continuous measures are often preferable to create ongoing incentives to improve
- QII program captures only some of the important quality measures
- Feedback must be timely; QII scores are tabulated quarterly
- The system must be designed to be administered efficiently and easily implemented

Pay-for-Performance Policy: Suggested Guiding Principles

- Develop a strategy that acknowledges the inherent complexity of P4P
  - » Delimit the patient care episode, and identify controllable and measurable activities that influence the quality of patient care
  - » Where possible use national standards and accreditations through recognized national professional associations.
- Create a program that is deliberately dynamic, participative and transparent
  - » Timely implementation may demand compromise
  - » Adopt a concrete program but modify goals and/or metrics over time
- Select metrics across a variety of dimensions
  - » Clinical processes and outcomes
  - » Patient perception
  - » Cost-effectiveness
- Lock in the gains and move the mean
  - » Adopt a CQI approach of addressing outliers AND shifting the mean