Assessing Physician Performance in Managed Care

Recommendations of the American Society of Internal Medicine

August 1995
<table>
<thead>
<tr>
<th>Contents</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td>6</td>
</tr>
<tr>
<td>Current Environment</td>
<td>7</td>
</tr>
<tr>
<td>What One Plan Measures</td>
<td>8</td>
</tr>
<tr>
<td>Do These Systems Really Measure Quality?</td>
<td>9</td>
</tr>
<tr>
<td>Recommendations</td>
<td>12</td>
</tr>
<tr>
<td>Effective Approaches to Assessing Physician Performance</td>
<td>12</td>
</tr>
<tr>
<td>Key Concepts for Maximum Positive Impact on Quality of Care</td>
<td>13</td>
</tr>
<tr>
<td>Conclusion</td>
<td>17</td>
</tr>
<tr>
<td>Endnotes</td>
<td>18</td>
</tr>
</tbody>
</table>
Increasingly, health plans use physician performance information to set compensation, to recredential physicians and to provide information on quality of care to consumers.

This policy paper provides practical recommendations on the responsible and effective development, use and dissemination of physician performance information to encourage continuous quality improvement within health plans.

ASIM believes that these new performance assessment systems can change the incentives in the health care system to favor quality of care and patient satisfaction as well as manage utilization and cost. However, it is important to properly balance the incentives in such systems among the various aspects of care and to use them appropriately to make sure that the highest priority is providing quality care to patients. After an extensive review of literature on quality monitoring and improvement, and on the advice of practicing physicians familiar with quality issues, ASIM has concluded that certain approaches to performance assessment and improvement are more effective than others in changing medical practice in a positive manner.

ASIM has identified nine principles that it believes are key to a successful, internal physician performance assessment program. ASIM recommends that managed care plans use these principles when developing and implementing internal performance assessment and improvement programs:

1. The primary focus of internal physician performance assessment systems should be to improve quality. ASIM supports the Institute of Medicine's definition of quality of care:

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.

Managed care organizations (MCOs) may evaluate physician performance in a number of areas, including clinical quality of care, utilization, access and service, cooperation with the health plan's quality improvement efforts, and patient satisfaction. Patient satisfaction with the care provided by a physician may be directly related to achieving desired health outcomes, and therefore should be a key element in a total program that assesses physician performance. Plans should not, however, give more weight to patient satisfaction than to direct assessments of clinical skills and disease-specific patient outcomes. Health plans should consult with enrolled physicians on the appropriate weights to be assigned to measures of clinical skills, patient outcomes, patient satisfaction, and other elements that may be included in a program for assessing physician performance.

2. The success of any performance measurement system will depend in great measure on the cooperative relation-
ship between the health plan and physicians. Practicing physicians should be involved in all aspects of the development, implementation and evaluation of physician performance data.

3. Internal physician assessment and improvement systems should be non-punitive and confidential in monitoring and improving quality.

4. Physician performance profiling or evaluation programs should provide physicians with nonjudgmental, comparative clinical performance information, derived from population-based data analysis and adjusted quality measurements, to promote quality improvement.

5. Plans should provide educational feedback on a routine and timely basis and should not initiate any adverse action toward a medical practice without allowing it opportunity to adapt.

6. Health plans should consult with practicing physicians in developing and refining performance measures. They should make these criteria or measures available to physicians. Physicians also should review the plan’s methodology for physician profiling.

7. Health plans should adjust physician performance profiles appropriately for such elements as case mix, severity of illness, age and sex of patients, size of a physician’s panel, number of comorbid conditions, and other features of a physician’s practice and patient population that may influence the results. Plans must give physicians the opportunity to review their profiles for accuracy and to request adjustments for particular characteristics of the patients they serve, before the plan takes any adverse action.

8. If a physician does not have adequate control over an element of care used to assess performance, that element should not be considered when measuring quality of care.

9. MCOs should not release internal physician performance profiles or evaluations to the public on a physician-specific basis. Instead, they should release aggregate performance data without physician-specific identifiers.

This ASIM policy paper is one of four published simultaneously on “Reinventing Managed Care.” The other papers, available on request, address access to subspecialty care, use of board certification in health plan credentialing of physicians, and assuring appropriate patient care under capitation arrangements.
Assessing Physician Performance in Managed Care

Introduction

The current health care environment is changing rapidly. As more businesses and public agencies look to MCOs for their employees' health care needs, there is a growing need for mechanisms that encourage quality in systems that offer financial incentives to use health care resources in a cost-effective manner. Across the country, managed care plans are experimenting with new kinds of internal performance assessment systems that reward physicians not only for quality of care but also for patient satisfaction, access and service, cost and utilization, practice growth, adherence to the managed care "philosophy," and board certification. MCOs often use the resulting physician performance profiles to encourage quality improvement, to determine physician compensation, and to make recredentialing decisions. Less frequently, MCOs make the profiles available to the public as a "report card" to demonstrate accountability.

These new performance assessment systems could improve quality of care and patient satisfaction and still keep costs low. Many are concerned, however, that these systems may focus only on quality of care but also on patient satisfaction, access and service, cost and utilization, practice growth, adherence to the managed care "philosophy," and board certification. MCOs often use the resulting physician performance profiles to encourage quality improvement, to determine physician compensation, and to make recredentialing decisions. Less frequently, MCOs make the profiles available to the public as a "report card" to demonstrate accountability.

The American Society of Internal Medicine (ASIM) is a membership organization that represents the nation's largest medical specialty. ASIM's members charged the organization with developing policy on the assessment of physician performance in managed care. In November 1994, ASIM asked internists to describe problems they had with managed care plans' administrative policies. The majority of the physicians surveyed listed the use of clinical outcomes or economic profiles (85 percent) and patient satisfaction survey information (64 percent) to assess physician performance as very important or important issues. In general, using profile data was the third most important issue for internists, only slightly behind capitation and scope of practice, and hospital admitting privileges.

ASIM's goal in this paper is to present practical recommendations on how responsible, fair and effective physician performance information can be developed, used and disseminated in the managed care environment. This paper addresses many questions, including:

- Do performance assessment systems really measure quality?
- What performance measures are appropriate for assessing physician performance and how should they be weighted?
- How should managed care plans approach performance assessment and improvement activities and what are the essential components of an effective quality improvement program?
- How can managed care plans enhance the credibility of performance information for physicians?

This paper also discusses the public release of physician-specific information.
Physicians increasingly find that MCOs are monitoring their individual practice patterns and style, and using this information in recredentialing and in setting payment levels. Many health plans also are considering whether or not to make physician-specific information available to health plan members.

In a 1994 survey, the American Medical Association (AMA) found that 39 percent of physicians surveyed were subject to clinical profiling, and 22 percent were subject to economic profiling. These results varied by specialty and type of employment. MCOs were more likely to profile internists than general or family practitioners or physicians in other specialties. Physicians employed by HMOs were the most likely to be subject to clinical profiling (48 percent), followed closely by physicians holding independent practice association (IPA) contracts (47 percent). Only 37 percent of self-employed physicians reported being subject to clinical profiling. Physicians holding IPA contracts were the most likely to be subject to economic profiling (28 percent), while physicians employed by HMOs were the least likely to be profiled on economic issues (19 percent).

Another extensive survey of managed care plans conducted for the Physician Payment Review Commission (PPRC) in 1994 found widespread use of profiling information by managed care plans. Of the 74 percent of survey respondents who said they used profiling information, 83 percent of those indicated that they used it in the recredentialing process, while 33 percent said they used the information when setting physician payment levels. The survey also found that HMOs and IPAs that pay physicians on a predominantly capitated basis were more likely to use performance data to set physician payment than plans that pay physicians on a fee-for-service or salary basis.

In early 1995, ASIM surveyed over 60 health maintenance organizations (HMOs) around the country and found that 89 percent of the respondents used clinical outcomes or economic profile information. The majority of the respondents (92 percent) said they used patient satisfaction survey information. More than 90 percent of the respondents indicated that they released outcomes and economic profile data to physicians. Fifty-two percent said the primary purpose of releasing this information was for educational feedback to encourage improvement. Four percent said they used this information to explain punitive actions, 10 percent said they used it “for other purposes.”

ASIM also learned that about half the respondents used clinical or economic profile information in setting physician compensation (58 percent) and making credentialing decisions (52 percent). Seventy-six percent indicated that they planned to release outcomes data to the public, though 62 percent said that they did not release economic data. Although the survey did not specifically ask whether plans released the data in aggregate or physician-specific form, the plans that elaborated on their policies generally indicated that they only released aggregate information. Only one plan indicated that it released information about the performance of individual physicians.

Less than half of the respondents used patient satisfaction data in setting physician compensation (45 percent) or in...
credentialing (48 percent), although the majority of plans (79 percent) said they planned to make patient satisfaction data available to the public. Forty-four percent already released such information to their enrollees. When asked in what form they published the performance data, 89 percent said it was in aggregate form. As one respondent pointed out, it was not useful to "bad mouth" their physicians in public by releasing individually identifiable information.

What One Health Plan Measures

There is a growing interest in the managed care industry to develop performance assessment systems that change the incentives in managed care to favor quality of care and patient satisfaction as well as control costs. These quality incentive programs are, for the most part, in the development stage. The performance elements that MCOs measure—and how they use the data—varies widely.

U.S. Healthcare, the largest MCO on the East Coast, is a leader in the performance assessment area. Its decade-old quality care compensation system pays primary care physicians bonuses based on their "total quality factor" score. This is the sum total of their performance in three different areas: quality review, comprehensive care, and utilization. Quality review is determined by patient satisfaction surveys, focused chart reviews, physician adherence to the "managed care philosophy," and member transfer rates compared to that of peers within the plan. The comprehensive care component is based on noncomparative performance measures, including membership size, practice growth, scheduled office hours, available office procedures, continuing medical education, internal practice coverage, catastrophic care, cooperation with patient management services, and computer link to U.S. Healthcare's network. The utilization review component is based on a physician's use of hospital, specialist and emergency department services compared to that of peers.

U.S. Healthcare places the most weight on comprehensive care measures, assigning them about 47 percent of the total quality score. Quality review measures make up about 36 percent of the total possible score, and utilization measures make up 17 percent. Compensation can increase as much as 29 percent based on the physician's total quality performance score. Score card topics are determined by regional committees composed of 12 to 15 practicing primary care physicians who meet on a monthly basis.

U.S. Healthcare supports performance improvement by providing monthly feedback to physicians on their performance relative to their peers. In addition, medical directors make site visits to discuss performance results with individual physicians. Physicians are given time to improve performance; however, performance information is factored into the credentialing process if a physician fails to meet minimum standards. U.S. Healthcare also is exploring the feasibility of making individual physician report cards available to health plan members.

The MCO rewards all positive behavior rather than targeting only poor performers. It says that pass-fail systems or systems that rate physicians alienate those who perform poorly—making them disinclined to improve—while those who pass become complacent. No objective study has documented the effectiveness of U.S. Healthcare's program. However,
chart audits conducted by the plan show improvement in some areas. For example, compliance among providers with cholesterol screening recommendations rose from 84 percent in 1988 to 94 percent in 1992.\textsuperscript{11}

Other plans appear to be following U.S. Healthcare's lead. According to the 1994 PPRC survey of managed care plans, most respondents used utilization or cost measures to set payment levels. Other performance measures commonly used by plans included patient complaints and grievances (49 percent), quality measures (46 percent), consumer surveys (36 percent), provider productivity rates (24 percent), and enrollee turnover rates (21 percent).\textsuperscript{12}

HMOs or IPAs that pay physicians on a predominantly capitated basis were more likely to use performance data to set physician payment than plans that pay physicians on a fee-for-service or salary basis. Seventy-eight percent of the HMOs and 74 percent of the IPAs that pay physicians on a capitated basis used utilization or cost measures in determining physician compensation. Seventy percent of the IPAs also used quality measures and patient complaints. Other measures mentioned by plans for use in setting payment included: peer review; compliance with administrative, utilization management and data requirements; compliance with the plan's care arrangements; attendance at seminars; patient turnover; and telephone access and hours of services. In general, the amount by which plans adjusted physician payment in response to performance data was under 5 percent.\textsuperscript{13}

Only a few plans reported using performance data in the initial selection process, probably because this information is not typically available. However, 72 percent of surveyed plans said quality review had “major value” for them in the recredentialing process. Slightly fewer (61 percent) said consumer complaints had “major value” in this process. Forty-three percent of plans said that quality concerns (including failure to meet quality assurance or improvement standards), malpractice claims, and member complaints, were the most common reasons for dropping physicians. Two-thirds of the plans also used profiling and consumer survey data in the recredentialing process, although they indicated that this kind of information only had “limited value.” Seventeen percent cited utilization or cost as reasons for dropping physicians. Plans also said they took into account performance information regarding problems with administrative or policy issues (18 percent); credentialing, licensing, or certification problems (14 percent); legal or disciplinary reasons (9 percent); changes in the network (7 percent); and inadequate access to services by the membership (7 percent).\textsuperscript{14}

**Do These Systems Really Measure Quality?**

**ASIM** supports the following Institute of Medicine (IOM) definition of quality of care:

\textit{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.}\textsuperscript{15}

In this era of cost containment and concerns about inefficiency, many people are talking about the need to assure
In attempting to manage health care costs and to allocate health care resources, managed care plans are using untried measures to evaluate physician performance. Defining and measuring quality of care is a difficult task, because "quality" can mean very different things to physicians and managed care plans. A recent study by the Employee Benefit Research Institute sums up this problem with the statement, "Quality is a multidimensional concept: it can be viewed narrowly (as clinical effectiveness) or broadly (as all attributes of medical care that patients value)." In attempting to manage health care costs and to allocate health care resources, managed care plans are using untried measures to evaluate physician performance. It is often unclear what relationship, if any, these measures have to quality of health care.

Physician performance may be evaluated in a number of areas, including clinical quality of care, utilization, access and service, cooperation with the health plan's quality improvement efforts, and patient satisfaction. ASIM believes that all these measures affect quality of care to some extent and it is appropriate to include these kinds of measures in performance assessment systems. For example, ASIM recognizes that access and economic concerns—such as appropriate utilization of health care services—are important attributes of care that should be considered when assessing quality. Patients need to have access to care and be able to afford it. Patient satisfaction with the care provided by a physician also may be directly related to the likelihood of achieving desired health outcomes, and therefore also should be a key element in a total program that assesses physician performance. Plans have a legitimate need to set measures for their own business purposes. This is necessary for managing medical care and limited resources in the most effective and cost-efficient manner possible. ASIM recognizes that health plans have the right to set performance standards and to use them as one element in assessing physician performance. For example, plans may hold physicians responsible for office hours, number of office procedures provided, and cooperation with the health plan.

For optimal patient care, however, ASIM believes that there should be a balance between clinical quality, cost control, access, patient satisfaction, and the managed care plan's business concerns. For example, too much emphasis on utilization and cost measures may lead to underutilization and diminished quality. With an overemphasis on patient satisfaction, the physician may respond too readily to patient de-
mands for high-priced services, even when a less expensive service or no service may be more effective. Also, health plans might focus too much on lowering premium prices, since price has been shown by many studies to be consumers' number one reason for selecting a plan. Again, a strong focus on lowering premiums may come at the price of diminished quality and underutilization. Conversely, focusing entirely on quality of care neglects real cost considerations in an environment with limited resources.

Deciding how to balance the disparate elements of quality is one of the most controversial tasks in developing a measurement system. As noted in a recent study, "Even if individuals agree on the disparate attributes of care that determine its quality, they may disagree about the relative importance of each attribute." Given the current pressure in the private sector to reduce health care costs and the financial incentives under capitation to underutilize services, it is important to make sure that quality of care should not be underemphasized.

As a general rule, ASIM firmly believes that no measure should be given more weight than direct assessments of clinical skills and disease-specific patient outcomes when evaluating physician performance. For example, plans often use board certification as the determining factor when selecting a physician instead of considering other valid measures of a physician's quality of care. (For more information on ASIM's views on the use of board certification in managed care credentialing, see ASIM's paper, "Reinventing Managed Care: The Use of Board Certification to Credential Physicians.")

Patient satisfaction, while an important outcome measure, should not have more weight than a physician's clinical skills. It would not be in patients' best interest to deselect a physician who has very good clinical skills but poor bedside manners. Moreover, patient satisfaction may be based on factors that are beyond the physician's control, e.g., whether or not the patient wanted to be enrolled in the plan or was assigned to it.

In addition, plans should not use performance measures to assess individual physician performance unless the care they measure is attributable to the physician and not to environmental or other factors. In an American Medical News article, "Grading the Report Cards," John Kelly, MD, then-director of the AMA's Office of Quality Assurance and Medical Review, warned that the managed care industry's increased interest and skill in monitoring physicians may lead to physicians being graded unfairly on things that are beyond their control. For example, he noted that patient compliance may have as much to do with mammography rates as the physician's performance. These things are useful for evaluating systems of care, but not necessarily individuals.

To select appropriate quality measures and to develop an appropriate balance between the various elements of quality, plans should consult with their enrolled physicians on the appropriate weights to be assigned to measures of clinical skills, patient outcomes, patient satisfaction, and other elements that may be included in a program for assessing physician performance.
Recommendations

Effective Approaches To Assessing Physician Performance

The ultimate objective of any performance assessment program is to translate performance information into action. Feedback of performance data has been successful in improving physician performance, especially if it is associated with other interventions. Feedback can have an effect on practice performance in two ways: as a regulatory "stick" to identify and punish "bad apples," or as a positive incentive to stimulate physicians to review and change their patterns of care. Experts believe that a health plan's approach greatly affects the impact its activities will have on changing physician behavior.

The punitive, bad-apple approach improves health plan performance by identifying and eliminating poor performers who fall below a certain acceptable level. This approach is likely to have less impact on a health plan's performance for several reasons. First, it focuses on outliers, by definition a small percentage of the population, leaving the majority of physicians unaffected. In addition, the average physician who "makes the grade" is inclined to become complacent. Second, the punitive approach sets up an adversarial relationship between the physician and the plan, making the physician less likely to cooperate in any effort to change behavior. Most experts in the field of quality improvement agree that cooperation is key to successfully changing physician behavior.

Before 1993—when it implemented its Fourth Scope of Work—the Peer Review Organization (PRO) program exemplified the regulatory bad-apple approach. Then the program focused on identifying and punishing individual cases of clinical error. Evidence collected by the IOM found that the PRO program spent $300 million a year to catch a few outliers who accounted for most of the serious quality problems in the country. The IOM specifically criticized the pre-1993 PRO program as "adversarial and punitive," and for not using "positive incentives to alter performance." The old program was universally seen as ineffective.

Another approach that many health plans are taking is to develop a highly quantitative score card, primarily so that purchasers can choose low-cost, adequate-quality providers (or alternatively, high-quality providers). This approach also may have limited impact on medical practice. According to the American Medical News article, "Grading the Report Cards," quality may suffer if plans place too much weight on the aspects of care that are reported while ignoring other aspects that may be more central to quality.

The most effective approach to profiling may be the one outlined by the PPRC in its 1992 annual report to Congress:

Although payers, consumers and credentialing bodies can take action on profiling results—using them to choose "good providers" and to sanction "bad apples"—this alone will probably do little to make American health care more appropriate and cost-effective overall. To play a role in achieving that goal, profiles will need to focus on providers as the agents of change, developing profiles and systems that will stimulate them to review and improve their patterns of practice.
This nonpunitive approach, often called the quality management approach, uses positive incentives and works when participating physicians are highly involved. It primarily focuses on encouraging continuous quality improvement. Several organizations have incorporated this philosophy into their quality oversight programs, among them the federal PRO program, the National Committee for Quality Assurance (NCQA), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Key Concepts for Maximum Positive Impact on Quality of Care

ASIM has identified the following key elements for a performance assessment program to have the maximum positive impact on quality of care:

1. The primary focus of internal physician performance assessment systems should be to improve quality.

Studies show that feedback is more successful when the objective is to improve quality of care rather than to decrease cost or utilization.24 Physicians, as patient advocates, are less likely to cooperate if the primary objective of an internal performance measurement system is cost savings or utilization management. For this reason, some researchers have suggested that internal measurement systems will influence physician practices more if their primary focus is quality, not cost.25 This approach assumes that since there is inefficiency and unnecessary care in the system, improving quality will lead to lower costs and greater efficiency.

2. The success of any performance assessment system will depend in great measure on the cooperative relationship between the health plan and physicians. Practicing physicians should be involved in all aspects of the development, implementation, and evaluation of physician performance data.

Most quality-improvement experts agree that physicians must believe in a program for performance data to have significant impact on practice. Participation is the best way to achieve physician trust. Logically, physicians are more likely to feel that the feedback process is fair if they know practicing physicians have had input into it, and less likely to feel that it is being imposed on them by a bureaucracy. Lack of involvement in developing quality definitions used by managed care plans, as well as how those measures are implemented, is a source of considerable frustration for internists.

Putting performance reports in the hands of groups of physicians can be an effective stimulus to action. The Maine Medical Assessment Foundation—a respected, independent, quality improvement foundation—advocates a collegial, educational and confidential approach. Practicing physicians convene to discuss issues, identify likely causes for practice variations, and develop approaches to improve performance without compromising outcomes.26 Physicians are eminently suited for this task. The foundation has enjoyed considerable success with its community-based, study-group model of quality improvement.

3. Internal physician assessment and improvement systems should be nonpunitive and confidential in monitoring and improving quality.
One way of gaining physician trust and support is to make internal physician assessment and improvement systems nonpunitive. Punitive approaches, such as the pre-1993 PRO program, are expensive and largely ineffective. As noted earlier, they only affect a small portion of the population and their threatening approach puts physicians on the defensive, making them less likely to admit they need to change their practice or use performance data to improve. On the other hand, positive incentives, such as educational feedback or rewards, encourage the entire cohort of physicians to improve.27

Complete confidentiality is key to gaining physicians’ trust and support. Physicians will be more willing to discuss performance issues in an open and frank manner if they know that the information is confidential. If they believe that performance information could potentially embarrass them, they will not be as willing to participate in improvement activities.

4. Physician performance assessment programs should provide physicians with nonjudgmental, comparative clinical performance information derived from population-based data analysis and adjusted quality measurements to promote internal and quality improvement.

Since appropriate provision of medical care is often a matter of degree, it makes sense to present comparative performance data in a nonjudgmental and nonthreatening manner. Various studies have shown that physicians are uncomfortable as outliers and will act on comparative performance information if it is provided to them. Adjusting quality measures for severity and other practice characteristics is key to convincing physicians that their practice is truly out of line with that of their peers in similar practices with similar patients, and that they need to take corrective action.

5. Plans should provide educational feedback on a timely and routine basis in the form of user-friendly reports with explanations of methodology to facilitate review by physicians. Plans should allow opportunity for practice adaptation before initiating any adverse action toward a medical practice.

Performance data have more impact when used as a positive incentive to help physicians review and improve their own patterns of practice. This can be done by framing the purpose of feedback as educational rather than punitive. Physicians are more likely to use performance data if they feel that the managed care plan is working with them to improve their performance. For example, it is useful for the managed care plan to support physician use of performance data by providing educational assistance. Also, research has shown that having an opinion leader present to endorse performance data is more effective than the simple feedback of information.

It also is important that physicians receive comparisons of their performance with that of their peers on a routine basis, so they can see over time how they are doing. To convince physicians that the feedback is educational and that the managed care plan wants to help them improve, the plan should allow the physician a reasonable amount of time to adapt his or her practice before any adverse action is taken. By the same token, the time between the end of the measurement period and the presentation of the informa-
tion should be minimal, so that the information is applicable to the physician's current practice.

6. Health plans should consult with practicing physicians in developing and refining performance measures. They should make these criteria or measures available to physicians. Physicians should be provided with appropriate information about the methodology used by the plan to conduct physician profiling to facilitate review by physicians.

Distrust and disbelief in the accuracy and significance of performance data is often the physician's first response when presented with practice pattern data. Physicians are more likely to accept performance measures as good and valid if they know that practicing physicians were involved in developing quality standards, and if they can check the validity of the methodology used to develop the data. Keeping performance criteria in a "black box"—as was often done by utilization review entities in the past in fear that physicians would game the system—only heightens physician distrust.

7. Health plans should adjust physician performance profiles appropriately for such elements as case mix, severity of illness, age and sex of patients, size of a physician's panel, number of comorbid conditions, and other features of a physician's practice and patient population that may influence the results. Plans must give physicians the opportunity to review their profiles for accuracy and to request adjustments for particular characteristics of the patients they serve, before the plan takes any adverse action.

Since practice and patient factors can have a substantial effect on utilization and outcome rates, it is important that plans properly adjust physician profile results to account for differences in physician practices and patient population. Physicians are unlikely otherwise to accept performance data as valid.

The literature indicates that adjusting profile data for sex, age and case mix can make a significant difference in profile results. A study shows that the referral rate for certain physicians initially identified as outliers decreased 24 percent when the profile data were adjusted for patient sex and age. Three-fourths of the physicians still identified as outliers when the data were adjusted for age and sex were no longer identified as outliers when the data were further adjusted for case-mix.28 Another recent study noted that even a simple case-mix adjustment analysis will improve the accuracy of individual physician profiles considerably, thus increasing the impact the profile has on physician behavior.29

ASIM recognizes that such adjusters are still under development. The recent PPRC study of managed care plans found that risk adjustment is common but limited. Of the plans surveyed, 51 percent risk-adjusted profiles for patient mix or health status. Adjustments for age and sex or other demographic variables are most common. One-quarter of the plans adjust profiles for patient health status by eliminating data for outliers, catastrophic cases, or specific diagnoses or comorbidities. Other common health status adjusters include severity of illness, type of benefits, size of patient panel, provider specialty, and the percentage of outliers.30 ASIM's survey found that about half of the plans adjusted quality and utilization data to take into account charac-
teristics of the physician’s practice that may affect profile results. For some types of information, such as patient satisfaction data, adjustments did not seem important and were rarely used.\textsuperscript{31}

\textbf{ASIM believes that physician-specific data should be strictly confidential.}

ASIM believes one way of getting around the current limitations of adjusters is to give physicians the opportunity to review their profiles for accuracy, and request further adjustments to account for particular characteristics of the patients they serve before the plan takes any adverse action. In many cases, individual physician profiles may be made more accurate by adjusting for readily-identifiable factors such as outliers, catastrophic cases, or specific diagnoses or comorbidities.

\textbf{8. If a physician does not have adequate control over an element of medical care used to assess performance, that element should not be considered when measuring quality of care.}

According to the PPRC study, only 51 percent of the plans surveyed said they could attribute results to individuals “reasonably well.”\textsuperscript{32} For this reason, when making credentialing and payment determinations, plans should be careful to measure only those elements of care that are directly under the individual physician’s control. To do otherwise is unfair and inaccurate.

\textbf{9. MCOs should not release internal physician performance profiles or evaluations to the public on a physician-specific basis. They should release aggregate performance data instead, without physician-specific identifiers.}

Some consumer advocates believe that releasing physician performance data will protect the public from poor quality practitioners. They also suggest that making such data publicly available will stimulate providers to improve their performance. Again, ASIM believes that physician-specific data should be strictly confidential. First, physicians are likely to view any release of performance information to the public as a serious breach of confidentiality. Almost certainly, it would have a chilling effect on their willingness to participate in quality improvement projects. Second, many medical researchers now say that consumers are not interested in the kinds of physician data that plans gather for internal assessment and improvement; they are interested instead in information about access to care and how others feel about a health plan. They don’t find profiling data useful.\textsuperscript{33} Third, until adequate severity adjustments are made to physician performance data, public release of this information could result in physicians with sicker patients being unfairly labeled as “over-utilizers” or having poorer outcomes.

On the other hand, the release of aggregate data about the health plan without physician-specific identifiers may be useful for a number of reasons, including health plan accountability, population-based quality improvement studies, and tracking the effect of new health care delivery systems on patient care.
Conclusion

The managed care industry is becoming increasingly interested in measuring and evaluating the quality of its medical care to identify areas for improvement. More health plans are using physician performance information to set compensation, recredential physicians, and provide information on quality of care to consumers. This paper has outlined practical recommendations on how to develop, use and disseminate physician performance information.

Many have raised concerns about the goals and the implementation of performance assessment programs. ASIM believes these new programs, if properly carried out, can provide incentives to improve quality of care and patient satisfaction, while also controlling health care costs. Managed care plans need to assess the goals of these programs carefully, to make sure their highest priority is to provide quality health care to their patients. ASIM believes that, for optimal care, performance assessment programs should achieve a balance between the various aspects of quality—including clinical effectiveness, cost and utilization—and patient satisfaction.

ASIM believes that some approaches to performance assessment are more effective than others. Specifically, ASIM believes that the most effective internal performance assessment systems are:

- confidential;
- nonpunitive;
- reward positive behavior;
- focus primarily on quality rather than cost or patient satisfaction;
- provide regular educational feedback and assistance;
- use appropriate and properly adjusted performance measures; and
- incorporate a high level of physician involvement in all aspects of their development, implementation and evaluation.

ASIM believes that plans may use performance information in making decisions about bonus payments or recredentialing individual physicians for participation in the health plan, provided that the information is consistent with these principles.
Endnotes


2. Ibid., p. 16.


7. Ibid.


9. Ibid., p. 37.

10. Ibid., p. 38.

11. Ibid., p. 36.

12. PPRC, op. cit., p. 88.

13. Ibid., p. 90.


15. EBRI, op. cit., p. 5.


17. EBRI, op. cit., p. 5.

18. Ibid.


25. Ibid.


27. Schoenbaum, op. cit.

Reinventing Managed Care


30. PPRC, op. cit., p. 118.


32. PPRC, op. cit., p. 118.