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DEVELOPING A FAIR PROCESS THROUGH WHICH PHYSICIANS PARTICIPATING IN PERFORMANCE MEASUREMENT PROGRAMS CAN REQUEST A RECONSIDERATION OF THEIR RATINGS

American College of Physicians

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DEVELOPING A FAIR PROCESS THROUGH WHICH PHYSICIANS PARTICIPATING IN PERFORMANCE MEASUREMENT PROGRAMS CAN REQUEST A RECONSIDERATION OF THEIR RATINGS

A Statement of Principles of the
American College of Physicians

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Executive Summary

Performance measurement programs offer a unique opportunity to benefit patients by creating incentives to improve quality. However, these programs also have the potential of influencing behavior in a way that may be incongruent with patients' best interests. The principles presented in this paper emphasize the importance of assuring that physicians are given the opportunity to comment on performance ratings that they believe are inaccurate, or that do not take into account the characteristics of the practice or patient population being treated prior to the release of ratings to the public. A fair and accurate reconsideration process is yet another way to minimize unintended consequences that may compromise the care of the patient. These principles reflect the importance of balancing stakeholders' urgent need for useful information with the need for due diligence to ensure that the information provided is valid, reliable, and useful. Accurate reports of physician performance allow physicians to effectively assess and improve their performance and enable consumers and purchasers to make informed decisions concerning treatments, coverage and the quality of care. These principles should be considered in tandem with other ACP principles on developing measures; sharing, aggregating, and reporting data; and the ethics of physician performance measurement.

Voluntary payer utilization of the following general guidelines should ensure a fair and accurate process through which physicians participating in a performance measurement program can request a reconsideration of performance ratings prior to public release:

- 1. Prior to public release of performance ratings to the public or use of ratings to determine payment, physicians should be given the opportunity to review the ratings for accuracy and, at the physician's request, initiate reconsideration of their individual ratings. The payer should employ all possible means to ensure that no adverse determination regarding physician performance be made without prior review by the rated physician, and, when requested by the physician, ratings should be reconsidered by an appropriate and objective group of reviewers.**
- 2. At the time of enrollment in a performance measurement program and again when ratings are first distributed for internal review, payers should provide physicians with a clear explanation of all program facets, including: the clinical guidelines and evidence that is graded upon which measures are based; the analytical methods used to aggregate, rate, and report data; the physician's right to an objective, timely, and expeditious reconsideration and appeals process; and a clear description of the reconsideration and appeals process, including the grounds for challenging ratings.**
- 3. Payers should have a well-defined and distinct mechanism for responding to physician inquiries and requests for reconsideration. Practical time frames must be established to ensure timely resolution of the contested matters and to minimize the delay of public reporting.**

4. In submitting a request for reconsideration, physicians should be given an opportunity to clearly identify the grounds for challenging the ratings. Physicians should be able to challenge the accuracy and fairness of the application of performance measures. Ratings may be challenged on a variety of factors, including: the validity, reliability, appropriateness, and applicability of the measure and its evidence base; the appropriateness of the statistical methods used to aggregate the data, including the size of the sample; the effectiveness of statistical adjustments (or lack of) used to account for confounding factors, including care attributable to the individual physician, case-mix composition, comorbidities, severity of illness, and patient nonadherence; the suitability of the measure implementation process; and the accuracy of the reporting format.
5. Submitting a request for reconsideration should not create an undue administrative burden on physicians to the extent that it discourages physicians from challenging ratings. Similarly, user fees and penalties should not be imposed on physicians who challenge performance rating decisions.
6. Fairness must be integral to methods used by payers to evaluate requests for reconsideration. Decisions about the appropriateness of ratings should be thorough and responsive to the concerns of the physician. In responding to physicians with the results of a reconsideration appeal, payers should state their findings and the clinical basis for their findings as clearly as possible.
7. The payer should establish unambiguous parameters to determine when a dispute cannot be resolved through an internal review process, and instead warrants consideration by an independent, external review or appeals board. These parameters should be set high enough to minimize the delay of public reporting and to preserve the goals of transparency.
8. If the physician still contests a rating after all mechanisms for reconsideration have been exhausted, the physician should be permitted to include comments adjacent to the disputed rating in the public report.
9. Payers should provide a central source for collecting, monitoring, and analyzing all inquiries and requests for reconsideration in order to enhance accountability, ensure that concerns are adequately addressed, and improve processes through the identification of recurrent issues and concerns.
10. If the physician successfully challenges an erroneous rating, he/she should receive full payment from the third party payer. Any “withholds” that may have occurred from physician reimbursement during the period of appeal should be paid within 60 days to the physician along with interest based on the medical Consumer Price Index.
11. Recognizing the importance of educating physicians about the potential difficulty and associated expenses of a performance measurement auditing process, the College will educate its membership about the appeals process and encourage its membership to use it judiciously to avoid frivolous appeals. ACP is willing to engage in a multistakeholder process to promote an appeals process that is fair and reasonable for both physicians and health care payers.

Introduction

Performance measurement programs offer a unique opportunity to benefit patients by creating incentives to improve quality. However, these programs also have the potential of influencing behavior in a way that may be incongruent with patients' best interests. For example, a performance measurement program can encourage some physicians to selectively exclude noncompliant or complex patients if physicians are unfairly penalized for poor, but unavoidable, outcomes. This could, in turn, produce adverse selection for other physicians who become responsible for a disproportionate share of such patients. There also exists potential for the creation of perverse incentives that emphasize inappropriate treatment and overutilization for patients with complex comorbidities¹. Such unintended consequences could actually reduce, rather than enhance, the quality of health-care – countering the very goal of performance measurement programs.

In previous papers², ACP identifies specific ways to minimize the unintended consequences of performance measurement programs that may compromise the care of the patient. First and foremost, ACP recognizes that it is critical that quality—not just cost reduction—always be the overriding measure of success in performance measurement programs. Programs that focus primarily on quality will ensure that patients' best interests are placed above all other priorities. ACP also recommends that measures based on the best available evidence be developed through a process that has broad consensus among stakeholders in the medical and professional communities; is validated by the National Quality Forum (NQF) and AQA Alliance; and is approved for implementation by a transparent multi-stakeholder organization. To further reduce the risk of unintended consequences, measures should focus on those elements of clinical care over which physicians have direct and instrumental control; data collection should be feasible; data analysis should be based on valid and reliable statistical methods that adjust for various risk factors; and reports should offer fair, timely, and useful feedback. Payers should consult physicians as early in the process as possible to improve the quality of measurement and reporting tools, to ensure that appropriate caveats regarding the weaknesses of the analyses are prominently displayed, and to notify physicians immediately of any changes to the program's measures or methods. ACP also recommends a phased-in implementation of performance measures to allow for the development of appropriate risk adjusters and other methodologies to reduce adverse unintended consequences.

The principles presented in this paper emphasize the importance of assuring that physicians are given the opportunity to comment on performance ratings that they believe are inaccurate, or that do not take into account the characteristics of the practice or patient population being treated prior to the release of ratings to the public. A fair and accurate reconsideration process is yet another way to minimize unintended consequences that may compromise the care of the patient. These principles reflect the importance of balancing stakeholders' urgent need for useful information with the need for due diligence to ensure that the information provided is valid, reliable, and useful. Accurate reports of physician performance allow physicians to effectively assess and improve their performance, and enable consumers and purchasers to make informed decisions concerning treatments, coverage and the quality of care. These principles should be considered in tandem with other ACP principles on developing measures; sharing, aggregating, and reporting data; and the ethics of physician performance measurement.

As the volume of physician performance data increases, so will efforts by various groups to challenge the accuracy of that information, especially when used for public reporting or payment purposes. These challenges will prompt more formal action to ensure the accuracy of information used by public and private payers. A 2005 national survey of trends in Pay-for-Performance (P4P) programs found that 77 percent of respondents provide an appeal mechanism whereby physicians can address inaccurate data, performance scores, or improper patient assignment³.

Despite this finding, there exists little or no research on the use of appeal mechanisms in programs that publicly report and base payment on physician performance. As a result, the principles included in this paper were developed by examining other areas of medicine, as well as other industries, that currently employ similar procedures. For example, the principles were based on positions taken by ACP and other medical associations to ensure that audits of Medicare charges and coverage determinations are performed in a fair and objective manner. They were also adapted from guidelines finalized by the Office of Management and Budget (OMB) in 2002 to maximize the quality, objectivity, utility, and integrity of information disseminated by federal agencies⁴, as well as from recommendations made by the U.S. Merit System Protection Board in its report on designing an effective P4P compensation system⁵. Ideas were also incorporated from a federal legislative proposal to establish a Medicare value-based purchasing program⁶, the American Medical Association's (AMA) "Guidelines for Due Process⁷," and accreditation standards and guidelines developed for insurance purposes by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Association of Insurance Commissioners (NAIC). Finally, principles developed by the AQA on performance measurement, reporting, cost of care, data sharing, and aggregation were also used to develop the principles in this paper.

Principles

Voluntary payer utilization of the following general guidelines should ensure a fair and accurate process through which physicians participating in a performance measurement program can request a reconsideration of performance ratings prior to public release:

- 1. Prior to public release of performance ratings to the public or use of ratings to determine payment, physicians should be given the opportunity to review the ratings for accuracy and, at the physician's request, initiate reconsideration of their individual ratings. The payer should employ all possible means to ensure that no adverse determination regarding physician performance be made without prior review by the rated physician, and, when requested by the physician, ratings should be reconsidered by an appropriate and objective group of reviewers.**
- 2. At the time of enrollment in a performance measurement program, and again when ratings are first distributed for internal review, payers should provide physicians with a clear explanation of all program facets, including: the clinical guidelines and evidence that is graded upon which measures are based; the analytical methods used to aggregate, rate, and report data; the physician's right to an objective, timely, and expeditious reconsideration and appeals process; and a clear description of the reconsideration and appeals process, including the grounds for challenging ratings.**
- 3. Payers should have a well-defined and distinct mechanism for responding to physician inquiries and requests for reconsideration. Practical time frames must be established to ensure timely resolution of the contested matters and to minimize the delay of public reporting.**
- 4. In submitting a request for reconsideration, physicians should be given an opportunity to clearly identify the grounds for challenging the ratings. Physicians should be able to challenge the accuracy and fairness of the application of performance measures. Ratings may be challenged on a variety of factors, including: the validity, reliability, appropriateness, and applicability of the measure and its evidence base; the appropriateness of the statistical methods used to aggregate the data, including the size of the sample; the effectiveness of statistical adjustments (or lack of) used to account for confounding factors, including care attributable to the individual physician, case-mix composition, comorbidities, severity of illness, and patient non-adherence, the suitability of the measure implementation process; and the accuracy of the reporting format.**
- 5. Submitting a request for reconsideration should not create an undue administrative burden on physicians to the extent that it discourages physicians from challenging ratings. Similarly, user fees and penalties should not be imposed on physicians who challenge performance rating decisions.**

6. Fairness must be integral to methods used by payers to evaluate requests for reconsideration. Decisions about the appropriateness of ratings should be thorough and responsive to the concerns of the physician. In responding to physicians with the results of a reconsideration appeal, payers should state their findings and the clinical basis for their findings as clearly as possible.
7. The payer should establish unambiguous parameters to determine when a dispute cannot be resolved through an internal review process, and instead warrants consideration by an independent, external review or appeals board. These parameters should be set high enough to minimize the delay of public reporting and to preserve the goals of transparency.
8. If the physician still contests a rating after all mechanisms for reconsideration have been exhausted, the physician should be permitted to include comments adjacent to the disputed rating in the public report.
9. Payers should provide a central source for collecting, monitoring, and analyzing all inquiries and requests for reconsideration in order to enhance accountability, ensure that concerns are adequately addressed, and improve processes through the identification of recurrent issues and concerns.
10. If the physician successfully challenges an erroneous rating, he/she should receive full payment from the third party payer. Any “withholds” that may have occurred from physician reimbursement during the period of appeal should be paid within 60 days to the physician along with interest based on the medical Consumer Price Index.
11. Recognizing the importance of educating physicians about the potential difficulty and associated expenses of a performance measurement auditing process, the College will educate its membership about the appeals process and encourage its membership to use it judiciously to avoid frivolous appeals. ACP is willing to engage in a multi-stakeholder process to promote an appeals process that is fair and reasonable for both physicians and health care payers.

As ACP has stated in previous position papers, programs measuring physician performance should operate in a fair, objective and scientifically sound manner. Performance data should be used for public reporting or to determine physician payment only after data are fully adjusted for case-mix composition, including age, severity of illness, comorbidities, and other features of a physician's practice and patient population that may influence the results.

Transparency is critical to ensuring that individual performance expectations and rewards are clearly understood by participating physicians. To bolster trust in the system, physicians need to understand the basis for rating and reward decisions, as well as the process by which those decisions are made. In their communications with physicians, plans and others implementing performance measurement programs should include a full disclosure of the process by which the measures were developed and the involvement of physicians and physician organizations like the ACP in both the measure development and implementation process. It should also be noted that the physician, before filing a complaint, should review such information—and if none were available, the omission in and of itself could be the basis for an appeal. Prior to submission of performance data, physicians should have the opportunity to ask questions regarding specific measures, data collection and aggregation techniques, and reporting methods. Payers must clearly delineate what is required of physicians to earn high performance ratings and obtain bonuses if the program is to further incentivize physicians to deliver better quality of care. Throughout the measurement process, payers should respond to questions from physicians in an accurate, consistent, and timely manner. Physicians that reasonably rely on written responses from a payer should be permitted to continue to rely on such responses throughout the reconsideration process.

Despite best efforts to adhere to these standards, there will be times when disagreement develops between the evaluating body and the physician. To further preserve objectivity, payers should institute a system wherein physicians can review and comment on any seemingly unsubstantiated rating prior to public reporting or use of results in determining payment. Physicians should be provided with a written statement that clearly defines the physician's right to request a reconsideration of his rating(s). This document should be distributed when a physician first enrolls in a performance measurement program, as well as when a physician is first given the opportunity to review his/her individual ratings, and should include the following information:

- The process by which a physician can request a reconsideration of a possibly inappropriate performance rating;
- The time frame for requesting a reconsideration and receiving a response;
- A general explanation of how determinations are made;
- An explanation of the different levels of reconsideration available, and of additional recourse offered if all levels have been exhausted and an acceptable agreement cannot be reached⁸.

The data upon which the payer determines the initial rating should be presented to the physician for examination. In addition to assessments of individual provider or group performance, reports should include appropriate contextual information to frame the purpose of the report, identify the source(s) of the information, and offer guidance on how to use the report appropriately for its intended purpose⁹. When payers first provide physicians with ratings for review, the ratings should be reported in the same format in which they will be pre-

sented in the public report, since the reporting format itself may also be a subject of dispute.

The reconsideration process should be objective and timely, allowing physicians to contest specific criteria that may have been inappropriately applied during the determination of a rating. A standardized form should be available to physicians who choose to request reconsideration. This standardized form should be developed through a consensus process with various stakeholders, including the National Association of Insurance Commissioners (NAIC), the NQF and AQA Alliance, and be used by all carriers and all physicians across the healthcare industry. On the form, the physician should be provided an opportunity to identify the grounds for challenging the rating(s), and to provide evidence in support of his performance. It is the physician's responsibility to be clear in describing how the rating fails to accurately reflect the physician's performance on the measure and what exactly should be corrected.

The payer has the right to ask for additional specificity in the request for reconsideration, an explanation as to why the correction is needed, and direction in locating the incorrect data in question as to avoid frivolous and repetitive complaints. In such cases, physicians will need to further demonstrate credible evidence of alleged misrepresentation. In support of their claim, physicians should be able to submit all evidence that could be found valuable to the reviewer, including items typically submitted during a medical review (e.g., the medical record), items not typically submitted during a medical review (e.g. physician's appointment book), and aggregate data from the practice (i.e., not necessarily just for a particular patient). At times, it may be cost effective for the physician or practice to hire a third party to analyze the data and/or make the case for reconsideration.

In considering physician's claims, the payer should re-evaluate the specific aspect of the measurement program being challenged against criteria of validity, relevance, and reliability. If there are recurrent physician concerns, it may be necessary for the payer to examine the program in its entirety to ensure that quality of care issues are given full consideration. Depending on the specific challenge, the following factors should be re-examined against criteria outlined in the AQA principles on selecting performance measures¹⁰ and aggregating¹¹ and reporting¹² performance data:

- **Evidence base:** Is the measure based on valid, scientific evidence and broadly accepted in the clinical community?
- **Validity:** Does the measure actually measure what it intends to measure?
- **Applicability:** Is the measure reflective of the overall clinical practice of that specialty? Did the measure appropriately determine eligibility for inclusion in an assessment?
- **Reliability:** Is the measure consistent and dependable—that is, would repeating the measurement in the absence of significant changes yield the same outcome?
- **Data collection methods:** Was data collected in a feasible and reliable manner across multiple physicians and sites of care? What was the source of the data (e.g., administrative or clinical data) and how may the type of data have affected the overall rating?

- **Adequate sample size for reliable estimates:** Is the measure applicable to a group of patients of sufficient size to provide a reliable estimate of an individual physician's performance?
- **Adjustment for confounding factors:** Were adequate mechanisms applied to correct the accuracy of data, including risk adjustments and other statistical procedures that account for factors that may confound results (e.g., case-mix, co-morbidities, severity of illness, and patient non-compliance)? Did physicians have the ability to opt out of a measure or to indicate that a patient was ineligible?
- **Care attributable to the individual physician:** Does the data analysis accurately reflect all units of delivery that are accountable in whole or in part for the performance measured? Did the type of measure (e.g. structural, process, outcome, patient-satisfaction) affect the ability of the measure to correctly identify the individual physician responsible for the care?
- **Time-specific modifications:** Does the data analysis account for performance measures time differentials? Was sufficient time allowed for a patient on a physician's panel to achieve the performance measure in question? Less time may be more reasonable for process measures, rather than for outcome measures (e.g., attaining glycemic or blood pressure control).
- **Reporting format:** Does the format in which performance information is reported (e.g., identification of superlative performers or underperformers, tiers, and rankings) distort the physician's performance? Performance ratings placing certain physicians beneath a benchmark provide less specificity about individual care patterns, whereas positioning physicians in tiered rank order performance categories could create opportunities to flag those who are consistently in the lowest tiers, allowing identification of the "worst in class¹³." Though more specific than benchmark reporting, rank order format should be implemented cautiously, to avoid adverse and undesirable physician behavior.
- **General standards for satisfactory performance:** Were quality-assessment criteria defined in enough detail to permit objective evaluations of the extent to which current practice meet criteria and ensure results that can be compared fairly among organizations? Were appropriate, operational definitions developed and provided for vague terms (e.g., "mild," "moderate," or "severe")? Were specific and appropriate time frames established for periods of performance assessment?

Physician performance consists of complex sets of interacting factors, some germane to the work environment, some to the physician, and some to the patient. Physicians commonly experience frustration with the inability to control all variables influencing individual performance, such as patient nonadherence and comorbid conditions, actions attributable to another member of the health care team, or lack of certain resources that allow the physician to meet a specific performance level. It is therefore critical that external constraints potentially affecting performance ratings adversely are carefully examined during the reconsideration process. An equitable physician performance rating process could also benefit payers by preventing such unintended consequences as limits on access to care or the "deselection" or risk selection of patients or categories of patients by physicians concerned about performance ratings¹⁴.

Payers may determine the specific design of the reconsideration process, and may include various levels. Generally, an internal review board should evaluate reconsiderations.

When a dispute cannot be mediated satisfactorily through this first stage, payers may refer the matter to an independent, external review board. An external review board should consist of appropriately trained, board-certified physicians who meet requirements for expertise and independence to prevent conflicts of interest, and who are in active practice with experience in the disputed type of care. The external review board should evaluate reconsideration requests against standards based on scientifically acceptable data and/or professional consensus. The payer should have written procedures for utilization of an external review board. The decision to use an external review board—and the length of time it may require— should take into account the needs of patients, physicians, and the goals of reporting. Additionally, the payer should be required to report to the external review board each request it receives for a review of a rating, and specify those for which the physician/group reports having to hire a third party to meet the payer's request for additional documentation. By tracking the number of grievances filed against a payer, the NAIC could easily identify payers who set erroneously difficult performance measures.

Regardless of reconsideration process design, it is the duty and responsibility of the payer to ensure that a fair, objective, and expeditious review of the contested rating is conducted pursuant to established criteria. It is critical that the reconsideration process does not create an undue administrative or financial burden on physicians to the point of discouraging physicians from requesting a reconsideration. The opportunity to challenge a rating can offer physicians redress against an unintentional, yet potentially detrimental, performance review. It may also help payers identify and calibrate broader functional problems with the performance measurement system, and reduce future misjudgments.

If, at any level of the process, the payer finds against the physician, even partially, the payer should provide the physician with a written decision that contains the reasons for the decision, the evidence or documentation relied upon, and a statement regarding any remaining rights of the physicians. If the physician is still not satisfied with the result after all opportunities for reconsideration have been exhausted, the physician should be permitted the opportunity to submit comments that will be printed adjacent to the contested rating in all public reports.

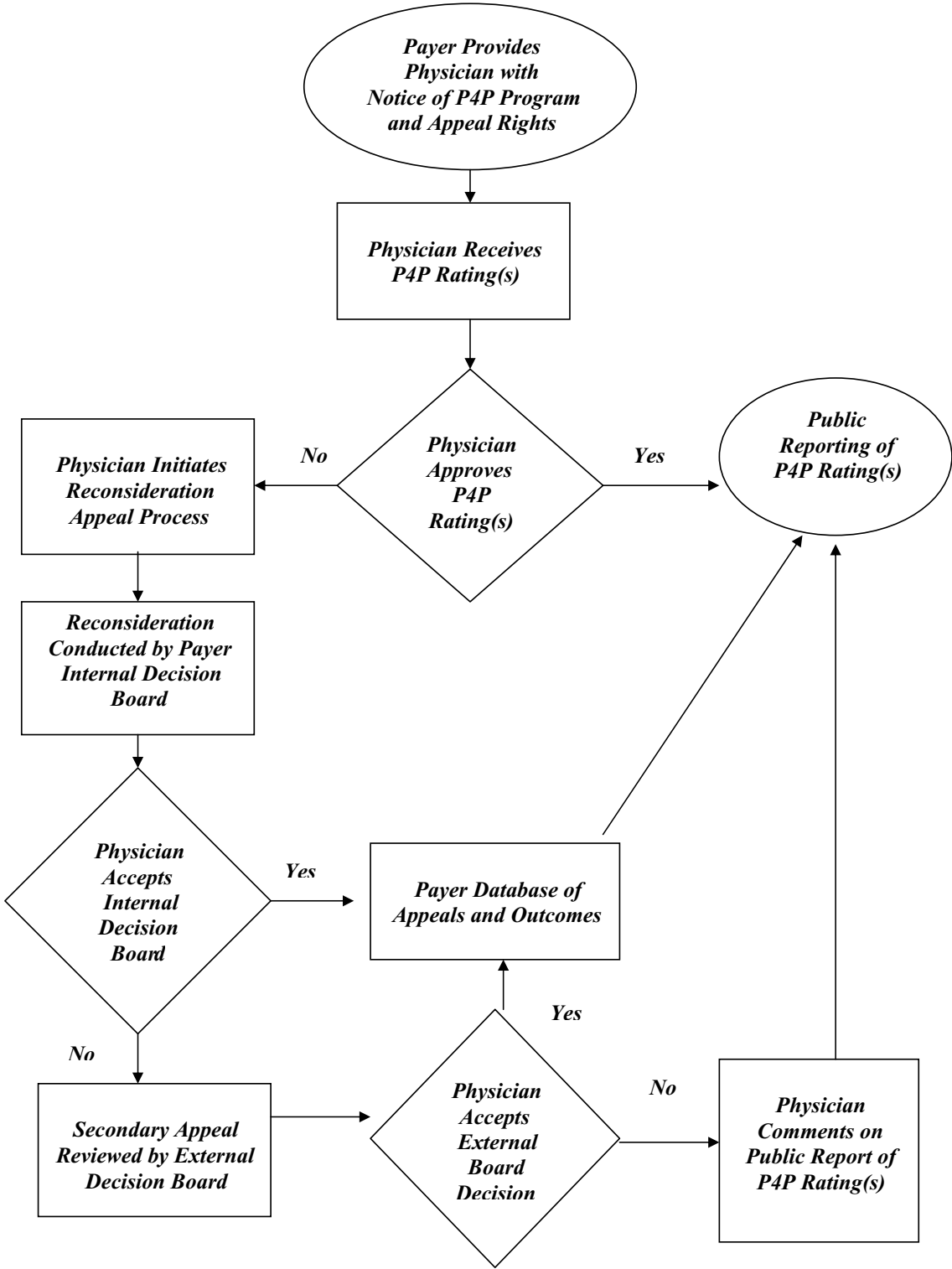
Conclusion

The science of physician performance measurement is directed towards 2 fundamental goals: to create measures that accurately assess the level of individual performance, and to create an evaluation system that will advance quality in health care¹⁵. The inclusion of a fair and timely reconsideration process in a physician performance measurement program is especially critical to ensuring that the 2 goals of physician performance measurement are preserved.

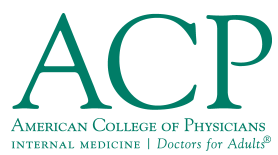
To balance the needs of patients, physicians, and the goals of reporting, payers must address individual concerns raised by physicians in an equitable and timely manner. Physician requests for reconsideration should be reviewed for quality of care concerns, including scientific validity and appropriateness of the measure, proper identification of confounding patient characteristics, proper attribution to the physician responsible for the factor being measured, and adequate case-mix adjustments.

The extent to which physicians have the opportunity to participate in performance measurement design; the quality and timeliness of information provided them; the degree to which the rules governing incentives are consistently followed; the ease at which physicians can challenge ratings that appear to be inaccurate; and the payer's safeguards against bias and inconsistency¹⁶ all will influence the physician's perception about fair treatment and enhance the program's ability to ensure that patients receive the highest quality of care.

Pay for Performance (P4P) Physician Reconsideration Process



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