

AAFP Members' Guide to Physician Assessment Programs

In recent years, there has been an increasing call for assessment of physician quality and efficiency. Patients, employers and health plan administrators all seek information about the value of health care. Determination of value requires some measure of both cost and quality. These programs may take the form of “report cards,” tiered networks, quality and efficiency ratings or performance reports available to individual physicians. Assessments can be publicly reported or shared confidentially with physicians and typically include peer comparisons.

The following frequently asked questions (FAQs) have been compiled to de-mystify physician measurement programs for AAFP members by addressing some common concerns. The AAFP is collaborating with the creators of physician assessment programs to help standardize them and assure that they are transparent. Like it or not, physician measurement and reporting are probably here to stay.

The ultimate goal of improving quality care persists and can only be actualized through continuous performance improvement activities that involve measurement and re-measurement. Most current physician assessment programs rely on administrative data and computerized algorithms to make the determinations. Administrative data include claims data, pharmacy data, referrals, lab order data and sometimes lab results. At the current time, very few programs require the physician to send in quality data from the clinical record.

Although these programs may not be perfect, they can give physicians important feedback about their clinical work and about actual costs. Family physicians have expressed concern about the methodology and the application. “Is the assessment fair and reliable and will I risk public discredit if my numbers become widely available?” See AAFP related policy on [Physician Measurement/Profiling](#).

Frequently Asked Questions:

1. Q. Isn't the health plan just using a “black box” to rate my performance?

A. When the AAFP has requested information about health plans' physician assessment programs they have been very open about sharing the details of their methodology for measuring both clinical quality and cost-efficiency. To assess clinical quality, computer software algorithms use clinically informed logic based on national quality standards and evidence based recommendations to determine if the available data fits the given rule. For example, the physician's claims data would be assessed to determine if patients with diabetes received at least two hemoglobin A1C tests in the last 12 months. For some conditions, multiple rules combine to determine if evidence-based recommendations have been followed. To determine cost-efficiency ratings, health plans utilize software to compare observed cost for an *episode of care* to the expected cost for episode of care, with patient severity of illness and the physician's case mix adjustments. The cost of care analysis is typically done on the individual physician level with comparison data from physician peers in the same medical specialty in the same market.

An *episode of care* refers to the services typically provided over the duration of a specific disease, condition or complaint. Some episodes are relatively short - less than a month (e.g. sore throat); some are intermediate - lasting several months (e.g. pregnancy) and some are chronic – tracked for 365 days (e.g. diabetes, hypertension).

There is a trend in the industry to make all of these rules and algorithms available for review by physicians and other interested parties.

2. Q. Why doesn't my health plan take a performance improvement approach to physician assessment rather than a punitive approach?

A. Many health plans do actually provide patient-specific feedback to physicians in order to close gaps in recommended care, e.g. a list of women who have not had mammograms within the last two years or asthma patients who are not on controller medications. The AAFP is working with all of the national health plans to try to keep these programs focused on good patient care, quality improvement and feedback to physicians that will support that care. Most pay for performance programs offer positive incentives for improvement rather than penalties.

3. Q. Why can't all the health plans agree on a single set of standards?

A. In fact, because of the limits of the administrative data set, most plans end up using very similar “rules” to assess quality and efficiency. Apparent contradictions in your assessment from different plans are more likely related to sampling error, attribution rules, small sample size or true random differences than the underlying measure specifications. Public pressure from consumer groups has forced health plans to use National Quality Forum (NQF) endorsed measures for most of these evaluations.

4. Q. Who endorses all performance measures on which I am being rated?

A. Performance Measures used by health plans may come from many different sources and are related to the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) criteria used to evaluate health plan performance. The National Quality Forum (NQF) is a public/private entity that uses a consensus development process to “endorse” performance measures for general use. Health plans are not required to use only NQF endorsed measures, but everyone agrees that a common set of standardized measures across all payers is the ultimate goal. Under new rules, accepted by most health plans, the NCQA will now evaluate physician assessment programs for validity and reliability.

5. Q. What data sources did the health plan utilize to measure my performance (e.g. administrative/claims, medical records, surveys, etc.)?

A. Most physician assessment plans use administrative data exclusively for determination of quality and efficiency. Although there are limits to its completeness, administrative data is readily available to health plans. Data from a selected sample of clinical records is required for some HEDIS measures. This information is collected by a manual audit of physician charts. Patient satisfaction with health plans or providers is assessed using surveys.

6. Q. Isn't administrative data likely to be faulty or incomplete?

A. Administrative data now includes claims data, pharmacy utilization, lab and imaging orders, referral information and often lab results. Keep in mind that the primary use of coding and claims submission has been for payment and not for documentation of care. The use of administrative data is constrained by issues of attribution, small sample size and lack of information from the clinical record. Even with these limitations, administrative data can provide valuable feedback to support quality improvement activities.

7. Q. Since I care for “sicker” patients in my practice compared to my peers, how can/does the health plan account for this in its assessment?

A. Most of the computer software algorithms used for outcome measures or efficiency determinations, incorporate some form of risk adjustment methodology. A familiar example would be “age and sex adjusted.” More sophisticated risk adjusters would take into account the number and type of co-morbid conditions and may use different risk adjustment for each condition.

We could push back and ask, “How do you know your patients are sicker?” Unless you have clinical measures and comparison data from peers in your same situation, it is hard to make that statement.

8. Q. What is the minimum number of cases/episodes used in my assessment? Is it statistically valid?

A. This may vary depending on the particular condition, and how many “logic rules” apply, but the trend in the industry is to determine a minimum number of rules to evaluate the individual physician for a quality designation. For primary care physicians, these rules might come from various patients with different conditions, such as five with diabetes, one with congestive heart failure and four with hypertension. If these minimums are not met, most of the plans will make a notation that there is inadequate data to rate/designate a physician’s performance. Efforts are underway to reach industry consensus on methods to assure statistical validity. These are more likely to rely on a level of statistical accuracy for a particular measure than a fixed number of patients or rules per physician.

9. Q. How do I know that the sample used by the health plan was representative of my practice?

A. It is safe to say that most current physician assessment programs are not measuring enough different conditions or enough patients with each condition to be able to evaluate your entire scope of practice. Each health plan may only have data on some portion of your patients and there are no measures for many of the services that you provide. The assumption is that if you are doing well on the things that can be measured easily, then you must be doing well on the other stuff. This may or may not be true. Ideally, the information will help point out possible areas for improvement within the scope of what is measured.

10. Q. If the health plan compares my costs to my peers in the same specialty, won’t it result in approximately 50 percent of physicians rated to statistically fall below the market average? If so, why doesn’t the health plan use targets/benchmarks?

A. Efficiency measures usually evaluate the cost of an episode of care. This is fairly clear-cut when the episode is something like a broken humerus, but gets a little fuzzy when the episode is diabetes in a patient with many other chronic diagnoses. In any given market, the health plan attempts to identify the high cost providers vs. the low cost providers. This is usually done by taking into account the confidence interval of the statistical data analysis. As a result, the split may well be 40/60 or the plan can set an arbitrary percentile, above which the physician will be designated as high cost. Most health plans use a comparative approach rather than setting a benchmark standard for the episode costs.

11. Q. How does the health plan determine which patient costs are assigned to me and are any costs incurred on behalf of that patient NOT attributed to me? What are they?

A. For primary care services such as diabetes, the patient is usually attributed to the physician who bills for patient services most often using that diagnosis code. Most algorithms require that at least 30% of the expenses for an episode to be attributed to the physician being evaluated. The industry is moving toward an approach incorporating different assignment logic for different types of episodes, such as cost for surgical episodes and contact measures for medical episodes. Lab tests, imaging studies, medications and visits that are logically associated with the diagnosis under consideration, are included in the cost calculation. If the diabetic patient consults a cardiologist for coronary artery disease and receives a diagnostic work-up, those costs would not be included in the primary care physician's cost computation.

12. Q. How can I be sure they are measuring the right things on my patients?

A. Physician assessment methodologies are useful, but have limitations. Medical costs are numeric, well documented and support precise analysis. Determination of the quality of care is less amenable to the same level of precision. Health plans measure the things that are easy to measure, not necessarily the things that are important to measure. Within a particular health plan, all physicians within a specialty are evaluated using the same methodology.

13. Q. Does anyone really look at the total value or effectiveness of care, not just costs?

A. We all know that this is very difficult and probably approaches impossible with complex patients. Health plans currently rely on a two-step process to evaluate quality and efficiency. The first step is to use the administrative data to determine if the care is consistent with the logic rules for the condition e.g., was a HgbA1c and an LDL done in the last twelve months. If a threshold is met, e.g. the logic rules that apply are met X percent of the time, the physician is designated as passing the "quality" portion of the test. Then, the episode cost is evaluated assuming a certain quality of the care as defined by the previous step. There are very few true patient outcome measures available from the administrative data set. The Centers for Medicare and Medicaid Services (CMS) now uses Current Procedural Terminology (CPT) II codes to report some patient outcomes such as the blood pressure or body mass index that would not normally be available in the administrative data set.

14. Q. How does the episode of care methodology assess the value of the services primary care physicians perform to prevent disease and save money, especially unnecessary hospitalizations?

A. This is not captured very well at all! Some health plans are evaluated through the NCQA measures on rates of hospitalization or emergency department (ED) use for things like CHF or Asthma; however, it is very difficult to get this same kind of data for individual physicians because the numbers of hospitalizations are too small to make a valid assessment. We hope to have information soon that documents the value of primary care services in reducing system costs.

15. Q. The sub-specialists and hospitals to whom I refer patients charge more than others do. How does the health plan take this into account?

A. For episodes where these costs would be attributed to you, your cost will clearly be higher than physicians who use lower-cost consultants and hospitals. The physician's cost

profile may be impacted more by the cost structures of hospitals to which the physician admits or the “referred-to” specialist admits. Because hospitals have different contracts with different payers, then it becomes more confusing and complex. As the move to greater transparency continues, the procedure or episode costs for the specialists and hospitals/facilities in your community should be available to you and your patients as you help them make decisions about where to get care. In the future, you will also have meaningful quality data to help determine the best course of action for patients.

16. Q. Is the health plan clearly reporting on the validity, accuracy, reliability and limitations of data utilized when reporting performance rating/tiering results and when providing physician feedback?

A. The short answer is “no!” Data for use by the public has to be presented in very easy to understand formats, like star ratings for restaurants or the number of dollar signs for relative cost. In that kind of presentation, there is no place for concepts like validity or reliability. Physician feedback should be presented in a way that guides action for improvement. The physician report must clearly identify the reasons and remedies for poor performance. Reports designed to support quality improvement generally do not require the same level of precision as reports intended for judgment or payment. Plans should provide this information to physicians, but it may not be readily accessible to patients. Patients may also find the presentation of information highly technical, making it difficult for them to understand without considerable explanation.

17. Q. Why was I rated highly in one plan but low in another?

A. The most common cause for this is sampling error or a small sample size used for the evaluation. Plans have become much more aware of these limitations in recent years, but might still send information for physician feedback and not use it for public reporting. Some plans combine other elements or requirements with the administrative data analysis to make up a composite score for quality (e.g. currency on Board Certification or maintenance of certification plan, participation in a quality improvement project or NCQA recognition program). In short, it is quite difficult to compare across health plans unless there are uniform criteria.

18. Q. I have the report. Now what are my options (e.g. ignore, validate, appeal, identify areas to improve, etc.)?

A. First, try to understand what it is telling you about your practice. Do not immediately assume that it is wrong because you do not like what it says. Health plans that are really interested in quality should provide reports that help identify opportunities for improvement and guidance for change. For example, if the report says that your costs are higher than peers in the same market, it should also help you understand the cause (e.g., You prescribed brand name drugs three times more often than peer physicians, you are referring to an out-of-network radiology facility or hospital, your sub-specialists perform medically unnecessary tests etc.). In most cases, public disclosure of these reports is unlikely to affect your patient volume significantly. Use them to find areas for improvement so that future reports will be more favorable. Most health plans have appeal procedures if you can demonstrate that the data is incorrect.

19. Q. How do I validate the data the health plan sends me prior to public reporting?

A. The natural human tendency is to assume it is correct if you pass and to assume it is incorrect if you fail. If the health plan gives you enough data to determine if the patients used in the analysis are actually seeing you as their doctor, then you have a place to start. Remember that the health plan probably made the determination based on bills you submitted for visits or services, so pull the charts and the billing records if possible. You may be able to verify dates of services or test completion, but you actually have no way to know about your efficiency compared to market peers. The health plan should supply cost and frequency information and specify what areas show a deviance from your peers (e.g., Higher imaging costs because you x-ray everyone with a cough; higher visit costs because you see everyone with bronchitis for three follow-up visits; higher pharmacy costs because you only use brand name antibiotics).

20. Q. How do I appeal my physician assessment/designation report?

A. The first step is to read the information provided with the report or the explanations on the health plan web site. If that does not clarify the specifics of the report, contact the local health plan medical director to make sure that you understand what it means. Determine if and how it will be used for public view. Have the medical director walk you through the findings and the possible causes for the adverse designation. He/she may be able to recommend opportunities for improvement and should be able to clarify the appeal or reconsideration process. If you are “stone walled,” at the local level, please contact the AAFP Private Sector Advocacy specialists and they will help get the ball rolling again. Most provider contracts will outline procedures for appeals and reconsiderations.

21. Q. What if my patients do not follow my evidence-based recommendations? (patient adherence) Will I be penalized?

A. Family physicians typically have a range of patients, from those who probably don't need much help from us to those who will not do well regardless of who is trying to help them. Assuming that you have enough patients with a particular condition, most of them are probably somewhere in the middle of this continuum. Remember that the measures are the same for all physicians in the market, most of whom face the same patient adherence problems that you have. Measures should not be set up so that the only right answer is 100%; there are too many factors that may not be in your direct control. For example, a diabetes measure checking the percent of patients with an HgbA1c less than seven might yield a number of about 50% as the best in the market. Non-compliance/non-adherence is a multi-faceted issue. Sometimes it is cultural or related to the patient's motivation, but part of it relates to the physician's ability to communicate with the patient in a way that engages them in their own care. There is clear evidence that systems like disease registries and patient self-management support can improve patient outcomes.

22. Q. What provisions, if any, do the health plans make to help ensure that the care provided by mid-level practitioners is separately identified from the supervising physician's performance rating report?

A. Ideally, each provider would be evaluated on performance individually, whether he/she is a physician, physician's assistant (PA) or nurse practitioner (NP). Because of the structure of the billing system, services provided by mid-levels may be billed as if it were provided by the physician (i.e., “incident to” the physician's services) or using the PA or NP's own ID code. Billing is done using the Tax ID number and may not contain individual provider

information. With the mandatory use of the National Provider Identifier (NPI) number after April of 2008, this should be less of a problem when it comes to assigning quality and efficiency assessments to individuals. Since data analysis requires a “look back” period, it may be 2010 before this problem is completely resolved.

23. Q. Will my performance rating or designation be publicly reported?

A. It depends on your local program. Some programs focus on quality improvement and there is more emphasis on feedback to physicians about individual performance relative to peers. Other programs are designed to produce a score or “report card” for public access where patients have to seek the information, usually on the Internet. Finally, quality and efficiency designations are sometimes used to “steer” patients to high quality, low cost physicians through benefit design, co-pay differentials or other inducements. In this case, your rating would only be seen by health plan members who actually search the provider directory. To date, most of these “steering” programs have focused on sub-specialty physicians and not on primary care physicians.

24. Q. Will I lose or gain patients because of the health plan’s public display of performance assessment/designation(s)?

A. This is a tricky issue to determine. If you have a large proportion of your patient population with a single health plan and you are excluded from their “high performance network,” you could see a significant drop in visit volume and income. Most primary care physicians are currently working **at or above** their capacity to see patients, so incentives to see more or threats that a few may have to leave, are not really very motivating. You will have to make this determination depending on your individual situation.

25. Q. What if the health plan sends me performance data that will not be used for public reporting or incentive programs?

A. We suggest that you try to be open about what it can tell you about your practice patterns as compared to your peers in the community. Are there systems that could help you do better? Does your office operate efficiently and incorporate a team approach to care. If the feedback is about patient satisfaction, where can you improve on timely service to patients through improved access and communication?

26. Q. Isn't my health plan just interested in saving money?

A. One important mission of all health plans is to moderate cost escalation under pressure from employers and government payers. Traditional utilization review (control) has largely given way to more emphasis on systematic feedback and education for improvement in quality, safety and efficiency. Most health plans have a commitment to high quality care for their enrollees because that is what payers expect as well.

27. Q. Does the payer’s report provide me an easy way to identify specific areas for improvement to achieve the stated measurement goal (e.g. HgA1c targets, preventive screenings, etc.)?

A. Most reports are likely to be limited to providing performance information in comparison to peers. Many of the plans have also developed programs to assist practices to improve performance, for example, they might pay for the cost of a chronic disease registry for

diabetic patients. The [AAFP](#) and [TransforMED](#) have a host of resources to help install systematic improvements in your office that are likely to help get better performance on these reports.

28. Q. Were actively practicing family physicians involved in developing the health plan's performance measures and assessment system(s)?

A. This varies from plan to plan. We have seen two important trends over the last few years. First, most of the national plans have developed physician advisory boards to solicit feedback from those who are closely connected to front-line medical practice. You cannot expect these advisory boards to stop this activity, but they should at least keep it somewhat practical and focused on patient care rather than just cost. The AAFP has been successful in nominating family physicians who sit on many of these advisory boards. The second trend is that most of the regional and national medical directors we see are now primary care physicians (many family physicians), which has certainly improved the industry sensitivity to the difficulties family physicians face.

29. Q. Will the health plan maintain a forum in which actively practicing family physicians can give feedback and share experiences on the effects of these physician assessment programs?

A. We have not seen any "user group" type activities develop around physician assessment programs. The plans have created more physician advisory panels to help facilitate input (see #28 above). The AAFP will continue to monitor this activity, to gauge the effect on patients and members.

Should you have any questions or issues with a specific private payer please contact your AAFP Private Sector Advocacy area at 1-800-274-2237, ext. 4172.