Insurer Ranking Systems Challenged in Mass.

BY ALICIA AULT
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The Massachusetts Medical Society has filed suit against a state agency and two insurers to "correct the wrongs" in programs that charge patients copayments based on physicians' performance ratings.

The suit is the latest in a series of broadsides against systems that purport to rank physicians, usually based on cost data extracted from claims. Physician groups have called that method flawed, and complained that often physicians have not been privy to how the ratings are calculated.

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The Massachusetts physicians said that the program developed by the Massachusetts Group Insurance Commission (GIC) is seriously flawed. For example, the medical society cites a neurologist who took on multiple sclerosis patients and used a team approach to care, having all of the providers' costs assigned to her, making it appear that she was a very-high-cost provider, the suit alleges.

The commission buys health insurance for about 300,000 state employees through six plans. Tufts Health Plan and the UniCare Life and Health Insurance Co., both of which were also named in the suit, had the most egregious practices, said Frank Fortin, a spokesman for the Massachusetts Medical Society, in an interview. UniCare began using tiers in 2006 and Tufts in 2007.

The suit was filed now because starting this month there will be three tiers instead of just two and more specialists will be subject to tiering, Mr. Fortin said. Primary care has not yet been included.

Mr. Fortin alleged that the distribution among the tiers was partly set by quota. The expansion will affect more patients, and, with the new rankings, "more physicians are in lower tiers because they were assigned costs from patients they did not treat and for procedures they did not perform," said Dr. Bruce S. Auerbach, president of the Massachusetts Medical Society, in a statement. The society does not oppose rankings, but said that the data are not accurate enough to be used to rate individual physicians.

Tufts wouldn't comment on the litigation. However, in a statement, spokeswoman Patti Embry-Tautenhan said that Tufts "developed physician tiering methodology with guidance from the Massachusetts Medical Society and other interested and affected parties in the health care community." She added, "Transparency of information regarding cost and quality is in the best interest of our members and health care consumers in general."

It's not the first time physicians have resorted to litigation. Rating systems instituted by UnitedHealthcare and Cigna Healthcare came under fire in Connecticut; a lawsuit filed in 2007 by the Fairfield County Medical Association is still pending. And, after filing suit in 2006 to block a Regence Blue Shield network, the Washington State Medical Association accepted a settlement last August in which Regence will continue to measure performance, but will engage physicians more directly in the process and make the programs more transparent.

The American Medical Association wants a settlement won in late 2007 by New York Attorney General Andrew Cuomo to serve as a national model. Cigna was the first to enter into the agreement. Aetna followed and said it would apply the agreement nationally. Empire Blue Cross and Blue Shield (a division of WellPoint), United Health, Group Health, and the Health Insurance Plan of Greater New York also agreed to the terms, within New York state.

The agreement was crafted by the attorney general, with the AMA, the Medical Society of the State of New York, and consumer groups such as Consumers Union and the National Partnership for Women and Families. It included a requirement that insurers publicly disclose rating methods and how much of the ratings is based on cost, and retain an independent monitoring board to report on compliance.

In early April, a group of physicians, consumers, employers, and insurers agreed to a voluntary program similar to the New York settlement. The Patient Charter was forged by the Consumer-Purchaser Disclosure Project.

Dr. Nancy Nielsen, AMA incoming president, said in an interview that the Massachusetts suit could have been avoided if the Patient Charter was in place. Rating systems are here to stay, however, she acknowledged, adding that the AMA does not oppose the programs on principle.

She said legislation codifying the voluntary standards would not likely pass Congress, because of insurance industry opposition. But when insurers don't follow the principles backed by physicians and consumers, "we'll go to the attorney general of that state," Dr. Nielsen said. ■

Physician Quality Can't Be Boiled Down to a Few Measures

BY MIRIAM E. TUCKER
Senior Writer

PITTSBURGH — Preliminary results from the American Board of Internal Medicine's Comprehensive Care Project confirm what many internists already know intuitively: Overall physician "quality" can't accurately be described using a single or limited number of conditions and/or measures.

"General internists play a central role in caring for patients with multiple medical conditions and comorbidities. However, current physician performance measurement typically focuses on quality measures for a single or a limited number of conditions," Dr. Eric S. Holmboe said at the annual meeting of the Society of General Internal Medicine.

Results of the ABIM's medical chart audit for 22,526 patients seen by 236 general internists showed wide variation both within and between physicians across a range of medical conditions, suggesting that "assessment of quality using limited numbers of existing performance measures appears not to be an accurate measure of comprehensive physician practice quality," according to Dr. Holmboe, senior vice president for quality research and academic affairs for the ABIM.

Invitations to participate in the project were mailed to 6,709 general internists with time-limited certification residing in 13 states that were stratified by 2005 state rankings of quality by the Agency for Healthcare Research and Quality (AHRQ). Participants in the performance project received an honorarium and points toward completion of maintenance of certification. Of the 254 physicians who began the project, a total of 236 completed on-site medical record audits.

Medical records were audited for six chronic conditions (diabetes, hypertension, coronary artery disease, heart failure, atrial fibrillation, and osteoarthritis); four acute conditions (upper respiratory infection, urinary tract infection, low back pain, and depression); and six preventive processes of care (smoking cessation counseling, influenza and pneumococcal immunizations, and screening for breast cancer, colon cancer, and osteoporosis). In all, 56 performance measures were abstracted for each physician's practice, said Dr. Holmboe, also of Yale University, New Haven, Conn.

The mean age of the 236 internists was 42 years, and 36% were female. Of the 190 who completed a survey component on practice systems, 36% were in solo practice, 30% in single-specialty practices, 25% in multispecialty practices, and 6% in academic faculty practice.

The medical record audit showed that characteristics of the 22,526 patients varied widely among the physician practices. The mean patient age per physician sample was 60 years, with a per-practice range of 44-77 years. The percentage of women patients averaged 60%, ranging from 10% to 75% per practice. Ethnicity was 37% white, 9% black, 8% Hispanic, and 46% undetermined.

An average of 95 charts was abstracted per physician. Most of the physicians were able to meet the request for at least 20 performance measures each for patients with hypertension (235) and diabetes (215), but fewer could provide the requested 20 for combined upper respiratory infection/urinary tract infection (187) and the three cardiovascular conditions (120), or the 10 charts for low back pain (208). Only about a third of the physicians were able to meet the targets for all six conditions, although half were able to meet the requested targets for at least five, Dr. Holmboe said.

Performance on process and outcome measures for each of the six conditions varied considerably. For example, the two measures with the least successful overall results were foot exams for diabetic patients (11%, range 0%-100%) and appropriate use of nasal decongestants for upper respiratory infections (5%, range 0%-100%). The two measures with the most successful results were weight documentation for heart failure patients (86%, range 0%-100%) and not prescribing drugs for low back pain (86%, range 36%-100%).

For physicians, although there was modest correlation between performance on chronic condition measures and on prevention measures, performance on chronic condition measures correlated poorly with performance on acute condition measures.

Correlation was even lower between performance measures of acute care and prevention.

These preliminary findings suggest that it is feasible to measure quality performance in a general internal medicine practice for some conditions but it may not be possible for all conditions in general internal medicine practices, Dr. Homboe concluded. ■