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Fair Process in Physician Performance Rating Systems: Overview and Analysis of Colorado's Physician Designation Disclosure Act

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Programs to rate, grade, rank, or tier physicians based on quality or other measures are becoming more commonplace as the demand for greater transparency and accountability in the nation's health care system intensifies. For many years, the preferred provider organization (PPO) reflected the most basic form of tiering—physicians were either included or excluded from the PPO network. However, this approach has become more refined as the tools for evaluating physician performance have evolved.

Once in a network or practice area, physicians may be rated in a variety of ways by health plans, payers, hospitals, and other entities that have some control over the physician's practice or payment. Rating may be used to reward high quality care and exclude, or steer patients away from, poor performers. In more and more communities and settings, mechanisms to evaluate and differentiate among physicians are under development as a way to promote clinical and economic value in health care expenditures, as the focus moves from solely expanding access to health care services to improving the purchasing of those services by consumers and payers. This trend reflects studies showing major deficits in health care quality.[1]

As health plans and other entities have begun to publicly report information about the physician quality and cost efficiency, physicians have expressed concern about the accuracy of the public information and the methods that are used to create this information. In order to safeguard the interests of both patients and physicians, government representatives have moved to regulate the rating of physicians and the public reporting of those ratings.

For instance, a physician rating system in Washington State prompted a lawsuit alleging defamation of physicians and violation of consumer protection laws as a result of the publication of inaccurate information.[2] In New York, the Attorney General conducted an industry-wide inquiry into physician rating by health plans and developed the New York Doctor Ranking Model Code,

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[1] Elizabeth McGlynn, et. al., The Quality of Health Care Delivered to Adults in the United States, *The New England Journal of Medicine*, 348, pp. 2635-2645.

[2] *Washington State Medical Assoc. v. Regence BlueShield*, No. 06-2-30665-1SEA, Seattle WA Superior Court (filed Nov. 29, 2006).

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which eight insurance companies have agreed to follow.[3] The New York Attorney General has followed a practice of sending letters to insurance companies that engage in physician ranking, warning that the rankings might violate New York consumer protection laws. After discussions and negotiations between the Attorney General and the targeted companies, the agreements that emerged are essentially settlements in which the company promises to follow certain procedures designed to ensure fairness and accuracy in the rating process. Companies also agree to be subject to the oversight of the state Ratings Examiner.[4] Since the state's initial agreement with CIGNA HealthCare, several other health plans have entered into similar agreements. At the same time, there have been efforts to develop processes prospectively for collecting and reporting quality data in a way that ensures accuracy and fairness while providing patients with useful information to make better health care decisions. An example of such a consensus agreement is the ''Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs,'' which is a voluntary set of principles for such programs that was endorsed by consumer, employer, and labor groups.[5]

Other states have taken a similar interest in how physician rating programs are developed. Citing the potential for unfair or inaccurate physician profiling, as well as the need for greater transparency of information about health care quality and costs, in 2008 Colorado enacted a law requiring minimum standards and specific procedures for health plan physician rating systems.[6] While the New York agreements and the Patient Charter apply only to those health plans that agree to abide by their terms, Colorado's law establishes procedures that must be followed by every health plan in the state. Similar legislation was introduced in the Oklahoma legislature in 2008 and in Maryland and Texas legislatures in February 2009. Thus, the potential for legislation affecting efforts to advance public reporting of physician quality measures is an increasing area of concern.

These developments reflect a longstanding tradition of laws aimed at protecting the interests of physicians in systems that involve performance evaluation. For example, the federal Health Care Quality Improvement Act (HCQIA)[7] is aimed at creating a fair process for hospital peer review determinations involving physician admitting privileges. Similarly, common law principles have been applied to decisions by health insurers to deny physicians membership in, or exclude them from, plan networks. In this sense, fair process laws related to physician ratings have a long history and considerable precedent.

Colorado's Physician Designation Disclosure Act

The Physician Designation Disclosure Act was signed into law on June 3, 2008, and took effect on Sept. 1, 2008.[8] The law addresses four key issues: data integrity; disclosure; fair process; and enforcement.

The law requires health plans to follow specific procedures and consider certain factors in designing any system for rating physicians. Specifically, it requires that any public representation of a physician's performance (such as a grade or tier) include a quality of care component and use statistically accurate and adjusted data that are appropriately attributed to the physician.[9] Any practice guidelines or performance measures used must be endorsed by National Quality Forum or a similar organization, a national physician specialty organization, or the Colorado Clinical Guidelines Collaborative.[10] The guidelines or measures must be evidence-based (whenever possible), consensus-based (whenever possible), and pertinent to the area of practice, location, and characteristics of the physicians' patient population.[11] The rating or designation must be accompanied by a disclaimer noting the risk of error and advising patients not to use the rating as the sole factor in choosing a physician.[12] Using a physician designation without this disclaimer is a violation of the law.[13]

In addition, the Colorado law gives physicians certain rights to information, notice, and due process as part of the mandatory procedures that health plans must follow with regard to any rating or designation system they intend to use. For instance, upon request, the health plan[14] must disclose to the physician its rating methodology and all data upon which the designation was based.[15] If contractual obligations prevent the disclosure of certain data, the health plan must provide the physician with enough information to determine how the withheld data affected the designation.

At least 45 days before using the designation, the health plan must give the physician notice of the designation and procedures for obtaining the information on which the designation was based and requesting an appeal of the designation decision.[16] The health plan's notice and appeal procedures must give the physician an opportunity to submit or have considered corrected data, to have the applicability of the methodology considered, to be assisted by a representative, and to have the designation decision explained by the person(s) responsible for it.[17] The appeal must be made to someone with the authority to modify the designation decision and to ensure that the designation is fair, reasonable, and accurate, and their decision must be made in writ-

[3] Office of the Attorney General, Doctor Ranking Programs, available at http://www.oag.state.ny.us/bureaus/health_care/HIT2/doctor_ranking.html.

[4] Office of the Attorney General, Press Release: Attorney General Cuomo Announces Agreement with Cigna Creating a New National Model for Doctor Ranking Programs (Oct. 29, 2007), available at http://www.oag.state.ny.us/media_center/2007/oct/oct29a_07.html.

[5] The Patient Charter (an initiative of the Consumer Purchaser Disclosure Project) is available at http://healthcaredisclosure.org/docs/files/PatientCharterDisclosureRelease040108.pdf.

[6] Colorado Revised Statutes (C.R.S.).§ 25-38-102.

[7] 42 U.S.C. § 11101 et. seq.

[8] Physician Designation Disclosure Act, Senate Bill 08-138 (Colorado General Assembly, 2d Sess. 2008). Available at http://www.state.co.us/gov_dir/leg_dir/olls/sl2008a/sl_403.htm (accessed Feb. 28, 2008).

[9] C.R.S. § 25-38-104(1)

[10] C.R.S. § 25-38-104(1)(f)(I).

[11] C.R.S. § 25-38-104(1)(f)(II).

[12] C.R.S. § 25-38-104(2)(a).

[13] C.R.S. § 25-38-104(2)(b).

[14] The law uses the term ''health care entity,'' which is defined as any carrier or other entity that provides a plan of health care coverage to beneficiaries.

[15] C.R.S. § 25-38-105(1).

[16] C.R.S. § 25-38-106(1).

[17] C.R.S. § 25-38-106(2).

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ing. The designation cannot be used until the appeal is completed, which should be within 45 days, and any necessary changes to a previously public designation must be made within 30 days after the appeal is final.[18]

An important procedural feature of the law is that all data submitted by a physician to the entity ''shall be presumed valid and accurate.'' This means that the burden is on the health plan to disprove the physician's data; if the physician submits corrected or supplemental data on appeal, the entity must presume that the new data are valid and accurate. At the same time, the law requires that a plan ensure the use of accurate data in its designation. Although the law prescribes certain procedures to help ensure accuracy, such as a method for determining measurement accuracy and the use of performance measures that are considered valid and reliable, it does not address how conflicting data should be reconciled. In short, it is not clear how the health plan should satisfy its obligation to ensure accuracy in the face of a presumption of accuracy for physician data, whether the data are submitted initially or on appeal.

In addition to providing for governmental oversight, the law specifically affords physicians a private right of action to enforce its provisions in a civil action. The law also makes all remedies available, including monetary damages and injunctive relief, such as an order preventing publication of the rating.[19] That means that physicians who allege harm as a result of a health plan's violation of the law can sue the health plan. Health plans are prohibited from limiting physician's enforcement rights, including through the use of contractual clauses waiving such rights.[20] A violation of the law by a health plan is deemed an unfair or deceptive practice in violation of Colorado's insurance code, which means that, in addition to the other privately enforced civil remedies described above, the state insurance commissioner can assess penalties and order the health plan to cease unlawful practices.[21]

Other Laws Requiring Fair Process for Physicians

Constitutional Protections

If the entity making a ranking decision is a state actor, such as a publicly-owned hospital or a state licensing board, then constitutional due process requirements may also apply. Due process usually requires notice and an opportunity to be heard and the right to present evidence in an impartial forum.[22]

Federal and State Statutes

Although the idea of rating physicians for public reporting purposes is part of a recent emphasis on ''value-based purchasing'' by ''health care consumers,'' the ranking of physicians in ways that may affect their livelihoods has created legal disputes for decades. Legal disputes arose out of actions such as exclusion of physicians from networks, participation in managed care plans, and designation of physicians as ''preferred providers.'' Out of concern for consumer choice and access to providers, many states have enacted ''any willing provider'' laws that require health insurers to allow any provider willing to accept the insurer's financial and other contractual terms to participate in that insurer's health plan.[23] These laws ensure fairness in the selection process by guaranteeing that providers will not be arbitrarily excluded.

The granting or removal of hospital privileges or membership in a group practice or professional society are other examples of quality-based judgments that affect a physician's ability to make a living. Such judgments are often the end result of a ''peer review'' process in which physicians are judged by other physicians. Many states have laws that impose procedural requirements on entities making these sorts of decisions in order to protect physicians' livelihoods while encouraging high-quality health care for patients.

In addition, the federal Health Care Quality Improvement Act (HCQIA)[24] sets minimum procedural standards by granting limited immunity from damages to physicians who participate in peer review actions (*i.e.*, actions that review a physician's competence and may adversely affect clinical privileges or membership in a professional society), as long as the action meets certain standards of fairness. HCQIA specifies ''safe harbor'' procedures that will satisfy the Act's notice and appeal requirements.[25] The HCQIA conditions its immunity provisions on certain conduct; for peer-review participants to be protected, the action ''must be taken: (1) in the reasonable belief that the action was in furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures [or other fair procedures] are afforded to the physician involved, and (4) in the reasonable belief that the action was warranted by the facts known after [reasonable effort].''[26] Peer review action is presumed to meet this standard but may be reviewed by a court for objective reasonableness.[27]

Common Law

Courts have implied state and federal common law duties of fair process or fair procedure in cases involving physician hospital privileges or physician participation in health insurance networks.[28] The duty of fair process arises from the general notion that private contracts may not contravene the public interest.[29] In a recent case, a California court of appeal applied this doctrine to the exclusion of a medical group from an insurer's preferred provider network.[30] The court explained that the doctrine of fair procedure applied to decisions that affected the public interest, particularly when there

[18] C.R.S. § 25-38-106(2)-(4).
[19] C.R.S. § 25-38-107(2).
[20] C.R.S. § 25-38-107(1).
[21] C.R.S. § 25-38-107(3)
[22] *E.g., Carlini v. Highmark*, 756 A.2d 1182 (Pa. Cmwlth. 1999).
[23] Currently, 21 states have some kind of ''any willing provider'' law. http://www.ncsl.org/statefed/health/AWP.htm.
[24] 42 U.S.C. § 11101 et seq.
[25] 42 U.S.C. § 1112.
[26] 42 U.S.C. § 11111(a).
[27] *Poliner v. Texas Health Systems*, 537 F. 3d 368 (5th Cir. 2008).
[28] *E.g.*, *Potvin v. Metropolitan Life Ins. Co.*, 997 P.2d 1153 (Cal. 2000).
[29] ''The implied covenant of good faith and fair dealing is an example of a common law application of public policy to contract law.'' *Harper v. Healthsource* N.H., 674 A.2d 962, 965 (N.H. 1996).
[30] *Palm Medical Group, Inc. v. State Compensation Insurance Fund*, 161 Cal. App. 4th 206 (2008).

were substantial economic ramifications.[31] In such cases, the doctrine required that the decision be both ''substantively rational'' (*i.e.*, not arbitrary, capricious, discriminatory, irrational, or contrary to public policy) and ''procedurally fair'' (*i.e.*, after notice and an opportunity to be heard).[32]

Discussion

In two respects the Colorado law appears to go beyond where the HCQIA, common law principles, or state statutory ''any willing provider laws'' go. First, the Colorado law appears to permit physicians to sue to recover damages in the event of error, even where the process is fair. Second, unlike common law situations, the Colorado statute appears to create a presumption in favor of physician-submitted data as part of the fair process itself. The extent to which these differences may have a chilling effect on the development of physician rating systems in Colorado cannot yet be known.

Unlike the Colorado statute for example, the HCQIA does not give private physicians a private right of action to sue for damages flowing from an incorrect decision; indeed, the act is designed to provide a defense for the decision-makers in the event of such an action, insulating them from liability for incorrect decisions as long as the process was fair. Thus, were a physician who had received a fair process review under the HCQIA to sue for injury under one or more theories (*e.g.*, tortious interference with a livelihood, defamation, or some other ground), the defendants would be protected if their decision-making process was fair. In this regard, the HCQIA is in a sense the mirror image of the Colorado law. Unlike the Colorado law, the HCQIA places the emphasis on fair process, while the Colorado law appears to expose even a fair process to private suit if the outcome is erroneous.

A key factor that may help explain the difference between the balancing of interests in the Colorado law and the HCQIA is that the former involves a decision by a health insurer, while the latter involves peer review. But the Colorado statute also appears to extend beyond common law, other state-designed efforts such as that undertaken in New York State, and state statutory principles applicable to network membership and exclusion, which all also involve actions by insurers rather than peers. The Colorado law is unique in how it strikes the balance between protecting the interests of physicians and encouraging the use of quality measurement systems. In Colorado's case, fair process provides no shield against private actions for damages arising from errors in measurement. How this balance of interests will affect future decisions to use ratings systems is a matter that bears close scrutiny.

Colorado's law is unique even as to its process provisions. Taken together, the laws discussed above reflect a general requirement that certain types of decisions affecting a physician's livelihood, similar to physician ranking decisions, be reasonable and that the provider receive adequate notice and opportunity for a fair hearing. The Colorado physician profiling law includes these requirements but goes further in protecting physicians by prescribing standards for the rating decision, specific procedures that must be followed both before and after the rating decision, and a presumption of correctness on the part of physician-supplied information, and imposes conditions on the publication of the rating. Historically, fair process laws have favored health care entities making a judgment about physician performance, effectively placing general safety and quality concerns over the specific interests of any particular physician. The Colorado law departs from that tradition, shifting the burden of proving the accuracy of data to the health plan making the designation decision.

In addition the Colorado law breaks new ground by giving individual physicians a right to sue for any violation of the law. The law also makes any violation of its terms a violation of the state insurance code, giving the state the right to sue to enforce it. Some advocates of public disclosure are concerned that the burden on health plans to comply with the extensive and detailed procedural requirements in the Colorado law, combined with the enhanced liability it imposes for even inadvertent failures to meet these requirements, will have a chilling effect on efforts to publish quality information about physicians for the benefit of consumers and payers.

It is important to note that the Colorado law applies only to health insurers or entities that offer health plans and do not appear to apply to an independent rating system that secures data from insurers. At the same time, insurers and plans may hesitate to furnish such data out of underlying liability concerns, since the provision of data to a third party could be interpreted as an effort to avoid application of the law by using a business associate, and may be less willing to collect the data from providers.

It is also unclear how state laws such as Colorado's will interact with new federal legislation that will require some level of provider performance measurement in Medicare.[33] CMS indicated that ''public reporting will play a key role'' in the physician value-based purchasing plan it is developing.[34] This federal initiative could result in performance measurement and public reporting procedures that, while not preemptive, could be very different from the procedures used by private insurers. These differences could frustrate efforts to move to the CMS-designed system for all payers or increase resistance to the development of different procedures by states or individual insurers.

In the meantime, organizations working on physician performance measurement and public reporting of quality data will have to navigate this changing environment carefully. The most prudent course of action would appear to be to work in partnership with physicians to win support for their performance measurement efforts and to inform lawmakers about the value of these collaborative efforts.

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[31] *Id.* at 215.

[32] *Id*. at 222.

[33] Medicare Improvement for Patients and Providers Act of 2008, PL 110-275 (July 15, 2008).

[34] http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Paper.pdf.

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