Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs: Ensuring Transparency, Fairness and Independent Review

The *Patient Charter for Physician Performance Measurement, Reporting and Tiering Programs* (the "*Patient Charter*") is supported by leading consumer, labor and employer organizations who share the conviction that public reporting of physician performance is integral to improving the health and health care of Americans. This *Patient Charter* applies to physician reporting programs developed by health plans to inform consumers. *These* organizations believe that health plans that evaluate, rate and report physician performance to consumers should be independently assessed. The review of such programs, coupled with full public disclosure of performance results will (a) promote the consistency, efficiency and fairness of these programs, and (b) make physician performance information more accessible and easier for consumers to understand. The *Patient Charter* is designed to encourage better performance reporting by striking the needed balance between standardization and innovation.

The endorsers of the *Patient Charter*, including AARP, the National Partnership for Women & Families, AFL-CIO, the Leapfrog Group, Pacific Business Group on Health and the National Business Coalition on Health invite all health plans to take the following actions:

1) Retain, at their own expense, the services of a nationally-recognized, independent health care quality standard-setting organization to review the plan's programs for consumers that measure, report, and tier physicians based on their performance. This review should include a comparison to national standards and a report detailing the measures and methodologies used by the health plan. The scope of the review should encompass all elements described in the *Criteria for Physician Performance Measurement, Reporting and Tiering Programs* (see page 2).

2) Adhere to the *Criteria for Physician Performance Measurement, Reporting and Tiering Programs* (see page 2) and make this adherence known to their enrollees and the public.

By adopting the *Patient Charter*, health plans acknowledge that independent review and validation of the integrity and fairness of their programs that measure, report and tier physicians are important to patients/consumers, purchasers and to physicians themselves. For their part, the endorsing groups believe that by accepting the terms of the *Patient Charter* health plans are agreeing to be assessed against high and consistent standards that will help to advance both the transparency and quality of performance measurement efforts, as well as promote the national consistency and standardization sought by consumers, purchasers, and physicians. (For additional details see companion document – *Background and Implementation Issues*.)

C/O National Partnership for Women & Families
1875 Connecticut Avenue, NW Suite 650
Washington, DC 20009
202.986.2600 • 202.986.2539 (fax) • healthcaredisclosure.org

Criteria for Physician Performance Measurement, Reporting and Tiering Programs

All elements in the *Criteria for Physician Performance Measurement, Reporting and Tiering Programs* should be publicly disclosed. In addition to this transparency, for some elements health plans' practices should be compared to national standards (these elements are identified below with "*").

1) **Measures should be meaningful to consumers and reflect a diverse array of physician clinical activities.**
   a) Measures should be directed at the six aims of the Institute of Medicine to the extent possible: care should be safe, timely, effective, efficient, equitable, and patient-centered. Whenever feasible consumer/patient experience should be assessed as a measure of patient-centeredness.
   b) The program/measures should provide performance information that reflects consumers' health needs. Programs should clearly describe the extent to which they encompass particular areas of care (e.g., primary care and other areas of specialty care).
   c) Performance reporting for consumers should include both quality and cost-efficiency information. While quality information may be reported in the absence of cost-efficiency, cost-efficiency information should not be reported without accompanying quality information. [1] *
   d) When any individual measures or groups of measures are combined, the individual scores, proportionate weighting and any other formula used to develop composite scores should be disclosed. This disclosure should be done both when quality measures are combined and when quality and cost-efficiency are combined.
   e) Consumers/consumer organizations should be solicited to provide input on the program, including the methods used to determine performance strata. *
   f) A clearly defined process for receiving and resolving consumer complaints should be a component of any program. *
   g) Performance information presented to consumers should include context, discussion of data limitations and guidance on how to consider other factors in choosing a physician (e.g., talking with your physician).

2) **Those being measured should be actively involved.**
   a) Physicians/physician organizations should be solicited to provide input on the program, including the methods used to determine performance strata. *
   b) Physicians should be given reasonable prior notice before their individual performance information is publicly released. *
   c) A clearly defined process for physicians to request review of their own performance results and the opportunity to present information that supports what they believe to be inaccurate results (within a reasonable time frame) must be a component of any program. Results determined to be inaccurate after the reconsideration process should be corrected. *

[1] These criteria do not apply to pure cost comparison or shopping tools that estimate costs for specific procedures or treatments, so long as it is made clear to the public that such tools and information are based solely on cost or price.

3) <u>Measures and methodology should be transparent and valid.</u>

a) Information about the comparative performance of physicians should be accessible and understandable to consumers, physicians and other clinicians.
b) Information about factors that might limit the usefulness of results should be publicly disclosed.
c) Measures used to assess physician performance and the methodology used to calculate scores or determine rankings should be published and made readily available to the public. Some elements should be assessed against national standards. Examples of measurement elements that should be assessed against national standards include: risk and severity adjustment, minimum observations and statistical standards utilized. Examples of other measurement elements that should be fully disclosed include: data used, how physicians' patients are identified, measure specifications and methodologies, known limitations of the data, and how episodes are defined. *
d) The rationale and methodologies supporting the unit of analysis reported should be clearly articulated (e.g., medical group or practice versus the individual physician).
e) Sponsors of physician measurement and reporting should work collaboratively to aggregate data whenever feasible to enhance its consistency, accuracy, and use. Sponsors of physician measurement and reporting should also work collaboratively to align and harmonize measures used to promote consistency and reduce the burden of collection. The nature and scope of these efforts should be publicly reported.
f) The program should be regularly evaluated to assess its effectiveness and any unintended consequences.

4) <u>Measures should be based on national standards to the greatest extent possible.</u>

a) Measures should be based on national standards. The primary source should be measures endorsed by the National Quality Forum ("NQF"). When non-NQF measures are used because NQF measures do not exist or are unduly burdensome, it should be with the understanding that they will be replaced by comparable NQF-endorsed measures when available. *
b) Where NQF-endorsed measures do not exist, the next level of measures that should be considered, to the extent practical, should be those endorsed by the AQA, national accrediting organizations such as NCQA or The Joint Commission and federal agencies. *
c) Supplemental measures are permitted if they address areas of measurement for which national standards do not yet exist or for which existing national standard measure requirements are unreasonably burdensome on physicians or program sponsors. Supplemental measures may be used if they are part of a pilot program to assess the extent to which the measures could fill national gaps in measurement. When supplemental measures are used they should reasonably adhere to the NQF measure criteria (importance, scientific acceptability, feasibility and usability), and may include sources such as medical specialty society guidelines. *