

Physician performance measurement: Tiered networks and dermatology (An opportunity and a challenge)

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INTRODUCTION

Over the past few years, the emergence of public profiling of physicians by health plans, pay-for-performance (P4P) contracts, and tiered provider networks have been heralded as endeavors to improve the delivery of medical care.^{1,2} Designed to align financial incentives and outcomes and rein in healthcare costs while demanding a purported higher quality of care, these efforts have been met with skepticism, confusion, and, at times, hostility from physicians.³⁻⁷ The medical profession, in principle, understands and supports efforts by insurance carriers to achieve more efficient and effective care. However, the execution of these programs has been concerning to the dermatology community in particular, given the challenges associated with identifying quality within this specialty in the ambulatory care setting and subsequently measuring it appropriately.

As healthcare reform efforts infiltrate specialty markets, it is critical that all stakeholders understand and are prepared for the changes that will impact the way patient care is promoted, paid for, and measured. Herein we discuss ratings of physicians as they apply to the practice of dermatology and how they are used to create tiered networks. In addition, we share how tiered networks, if not implemented correctly, may undermine the improvements they seek. Finally, we suggest strategies for both payers and providers that will support transparency,

collaboration, and, ultimately, the provision of quality dermatologic care.

BACKGROUND

Increasingly, payers are using profiling tools to rate physicians' performance on the basis of the cost and quality of the care they provide. Software programs are readily available to help insurance companies analyze physicians' claims data in an attempt to assess their quality and cost-efficiency relative to the performance of their peers. Health plans and medical groups use these data for a variety of purposes, including contracting, providing feedback to physicians, and for quality improvement. More and more, performance data are shared publicly either in the form of physician or practice report cards or through the creation of tiered networks.

A tiered provider network assigns physicians into separate tiers, based on cost and quality indicators. The extent to which cost-effectiveness and quality are used and weighted to establish such tiers varies from payer to payer and is not standardized. For example, Aetna selects physicians or groups to participate in its Aexcel tiered network based on 4 factors: volume, clinical performance, cost efficiency, and network adequacy.⁸ As of September 2004, the Aexcel network included between 40% and 70% of the physicians in Aetna's existing specialist network in a given region.

Tiered networks use copayment or coinsurance differentials, among other incentives, to "steer" patients to what the insurance plan considers the highest performing providers. For example, if a health plan considers Dermatologist A to provide high-quality and cost-effective care, the patient might pay a reduced office visit copayment to see Dermatologist A. If Dermatologist B is rated as lower quality and not cost-efficient, the patient might pay a higher copayment to see Dermatologist B. The intent is to (1) encourage patients to seek out physicians who provide higher quality care in a more cost-effective manner and (2) encourage physicians to improve the quality and efficiency of the care they provide.

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Funding sources: None.

Disclosure: John Freedman is principal at Freedman Healthcare, LLC, which consults with both providers and payers on issues of healthcare performance measurement and improvement. Drs Gottlieb and Lizzul have no conflict of interest to declare.

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J Am Acad Dermatol 2011;64:1164-9.

0190-9622/\$36.00

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doi:10.1016/j.jaad.2010.07.004

Cost and quality indicators within dermatology are limited and often do not reflect factors, such as case mix, severity of illness, or practice setting. A dermatologist who is expert in a subspecialty area may receive referrals from peers; their practice then consists of patients who need the highest level of intervention, which is often associated with the highest cost. Within a traditional tiering model, this physician would receive lower ratings for being less cost effective even if providing the highest quality of care.

While tiered network plans have been a small segment of the market, evidence suggests a changing dynamic. As of January 2003, more than 1.5 million Americans were enrolled in health plans with tiered networks. Virtually all used both cost and quality as the basis for tiering.⁹ A Hewitt survey reports that 5% of employers offered a multi-tiered network plan in 2005 and that 7% did so in 2006.¹⁰ The Kaiser/HRET survey data suggested that 2% of employers were “very likely” and 16% “somewhat likely” to adopt tiered network plans in 2005.¹¹

While dermatology is one specialty that has been excluded from some tiered plans, the Cigna Care designation program includes dermatology in 58 markets, and Humana Preferred includes dermatology in 15 markets. Smaller plans, such as Tufts Health Plan and Harvard Pilgrim Health Plan, have tiered their dermatology providers. With health care reform under way across the country, and President Obama’s commitment to payment reform on a national level, the dermatology community must prepare for increased scrutiny of physician performance and tiered networks.

CONCERNS ABOUT TIERING

Thomas Lee, network president at Partners—Massachusetts’s largest provider network—stated that tiered networks were “creating a fair amount of angst among providers, to put it mildly.”¹² Impacted physicians, including dermatologists, are concerned about the potential negative impact of tiering. These possible negative impacts include the possibility of losing patients who cannot afford a higher copay to choose a provider in a higher priced tier as well as the lost revenue resulting from the inability to collect increased copayments from patients. In addition, the possibility of having physicians assigned to two different tiers within the same office is burdensome to practice managers. In some payer tiering systems, quality may be weighted less than cost or even excluded entirely.

Naturally, we would expect physicians to legitimately fear being identified as a poorer performing physician on the basis of erroneous data or assumptions. Incorrect or invalid cost and quality ratings

have the greatest potential for harm as they may both reward the wrong physicians and harm the quality and efficiency of care by encouraging patients to see poorer performing physicians. Furthermore, erroneous ratings compromise the trust of patients and physicians, which is critical to the long-term success of performance measurement and tiered networks. Additional unintended consequences of tiering or poorly developed quality performance measures would include adverse selection by limiting access to care for the sickest patients. As tiered networks become more widespread, we believe that data analytics need to become more sophisticated to ensure the highest level of accuracy and efficacy.

ACCURACY OF RATINGS

The accuracy and relevance of physician ratings depends on multiple factors including data collection, analysis, and presentation. Cost data mainly derive from paid claims (including inpatient, outpatient, pharmacy, and ancillary service claims), which are analyzed by the use of specialized software to enable comparison among similar physicians. Quality data most often come from claims data and may include survey information on patient experience with the physician or the practice’s infrastructure, such as electronic medical records. Survey data are collected from patients and physicians as appropriate. Health plans may review Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospital Survey results, which includes information about the doctor-patient communication and the process of care. Quality information may be excerpted from medical records; however, unless the records are electronic, the cost of collection is prohibitive.

Medicare relies on the Physician Quality Reporting Initiative (PQRI), which uses evidence-based quality measures created through the Physician Consortium for Quality Improvement, and are submitted for endorsement to the National Quality Forum. Private payers, on the other hand, may use different quality measures and generally measure cost by using episode grouper software or develop their own cost measures when creating tiering systems. Because each private payer may use different measures, dermatologists must stay informed so they know how they are being evaluated.

Data used to measure physician performance must be reasonably complete, timely, and accurately reflect the services rendered and diagnoses made. However, even with these safeguards in place, such data will not capture the full scope of factors that determine quality of medical care. There is still an art to the practice of medicine, and medical care must also be flexible so that it can be personalized to

individual patient needs. The data must then be analyzed by expert analysts, using proper investigative and statistical techniques. The analysts must ensure that services are properly “attributed” to the physician(s) responsible for each episode of care. Factors contributing to methodological accuracy are listed in [Table I](#).

To achieve clinical relevance, the database must include information applicable to a cross-section of dermatologic practice ([Table II](#)). We support AMA guidelines regarding PFP programs, which assert they should achieve the following: promote quality supported by evidence-based guidelines; be targeted toward gaps in care that produce significant morbidity and mortality; and minimize perverse incentives to abandon needy patients by taking into account case mix. Moreover, P4P programs must promote quality and encourage best practices, but not dictate how a physician practices. We believe there should also be incentives to offset the expense of implementation of such programs and attempts to minimize the burden of reporting. If the goal of P4P or tiering is to improve quality, then overall impact as well as the achievement of thresholds should be measured. In addition, poor outcomes do not necessarily imply a quality problem, as many outcomes are out of the provider’s control.

When measuring quality, dermatologists unfortunately do not have the variety of validated quality measures that are available for physicians in other specialties, such as internal medicine, pediatrics, or cardiology. In Massachusetts, 3 health plans rate the quality of dermatologic care with a common set of 4 clinical measures ([Table III](#)). The measures, however, fail to cover much of clinical practice, show little variation, and may not be accurately reflected in claims data.¹³ Common conditions, such as actinic keratoses, warts, acne, rosacea, dermatitis, and psoriasis, are virtually excluded from these 4 measures, despite the fact that they comprise a large portion of typical practice.

Measurements must have sufficient sample size to be accurate. Smaller health plans, which cover a small portion of a dermatologist’s patients, cannot collect enough data to draw accurate conclusions about the practice’s quality or cost. Similarly, low-volume practices, such as part-time practitioners, may not have enough patient volume even with a large health plan for accurate measurement.

SPECIFIC EXAMPLES OF ISSUES IN EXISTING TIERED NETWORK PLANS

Tiered networks pose several challenges to the dermatology community, which may be more effectively addressed with better communication between

Table I. Factors necessary for methodological accuracy

Reliable data source (eg, paid claims, patient surveys, practice surveys)
Sufficient sample size (number of cases and patients per physician)
Validated performance measure (ie, measure has been tested to ensure it measures what it purports to measure)
Proper identification of physicians and their specialties
Proper assignment of patients’ services to their physician(s)
Choice of proper comparison benchmarks (especially for sub-specialized physicians)
Appropriate handling of outliers—outlier patient cases, conditions, and physicians

Table II. Factors necessary for clinical accuracy

Data are a representative sample of the physician’s clinical practice.
Chosen measure address issues of importance to patients (eg, treatment outcomes, evidence-based processes of care, patient experience)
Ratings reasonably capture the practice patterns of the rated physicians.

physicians and those creating performance measures as well as the creation of appropriate measurement tools. The Greater Rochester Independent Physician Association (GRIPA), which is a large IPA that includes nearly 100% of Rochester, New York area physicians (including a significant dermatology community) involved physicians in the drafting of clinical guidelines as part of its GRIPA Connect initiative. Clinical integration committees (CICs), consisting of primary care and specialist physicians, meet monthly to select, modify, and evaluate clinical guidelines used to measure member performance. The CIC receives input and recommendations from specialty advisory groups, which include physicians from each of the specialties and subspecialties affected by the guidelines that are being developed.

When measuring cost, it is especially critical that dermatologists be compared with appropriate peers. For example, general dermatologists should not be compared in the same group as Mohs surgeons, who tend to incur higher costs than general dermatologists, even for the same diagnosis. Because patients are often referred to Mohs surgeons expressly to have an expensive procedure performed, this subspecialty will appear more costly than general dermatologists.

Table III. Dermatologic measures of quality and their limitations²⁰

1. Incidence of pregnancy in patients using isotretinoin	Should be an extremely rare occurrence, thus unlikely to discriminate among dermatologists
2. Use of lotrisone in patients with tinea pedis, tinea cruris, or tinea corporis	Should be an extremely rare occurrence, thus unlikely to discriminate among dermatologists
3. Annual skin exams in patients with a history of melanoma	Claims may not include CPT code for complete skin exam; may underestimate performance.
4. Annual skin exams in patients with a history of nonmelanoma skin cancer	Claims may not include CPT code for complete skin exam; may underestimate performance.

Failure to adequately account for the differences in the severity of illness of patients seen by different dermatologists will lead to inaccurate results. Therefore the measurements must either be risk adjusted for severity of illness, or dermatologists should be compared with peers who have similar patient populations. Certain subspecialists may not have enough relevant peers for comparison purposes. For example, consider a subspecialist in contact dermatitis, immunodermatology, or psoriasis whose practice consists of a relatively high percentage of severe or recalcitrant cases referred from other dermatologists. This physician will likely have substantially higher pharmacy costs (from the use of more expensive biologics) and ancillary costs (for patch testing) and will therefore appear less cost efficient than general dermatologists. If a region has few of these subspecialty physicians, there may be no valid benchmark available. In that case, such physicians should be excluded from tiering. The actual practice setting within a region should also be considered. For instance, comparing private practice to an academic practice, or an urban practice to one in the suburbs, may not accurately reflect cost, outcomes, and quality. If the patient population is different from the average population, and those differences are not accounted for, then erroneous ratings will result. Proper adjustment for severity of illness and other relevant factors must be included in a successful measurement program.

PHYSICIAN REACTIONS TO TIERING

Some physicians have responded to tiered networks with acceptance, recognizing the opportunity for practice improvements and hoping their performance would warrant selection of them for the high-quality/low-cost tier. Some dermatologists have engaged with a few health plans that value physician input, serving as physician advisors in an effort to improve the rating system or at least to avoid major problems.

Yet, other physicians have been more skeptical about the tiering process and have even taken legal

action. For instance, the Washington State Medical Association sued Regence Blue Shield in 2006 over Regence's physician ratings.¹⁴ The Massachusetts Medical Society has sued Massachusetts' Group Insurance Commission, the state agency that administers health benefits for 275,000 state employees and dependents, over its tiered network plans.⁷ New York Attorney General Andrew Cuomo reached a settlement with several health plans with an agreement to follow a series of principles to improve their physician ratings programs.¹⁵

These concerns are not surprising, given that there are a number of negative implications of current physician-tiering practice in which the algorithms penalize physicians caring for the sickest patients and the degree of illness, or disease severity, of the patient is not well accounted for. Because disease-specific clinical outcomes are not measured, some dermatologists will be disadvantaged in the ratings. They may therefore choose not to sacrifice their cosmetic and surgical practices for ill medical dermatology patients. Thus sick patients may find it harder to find an available dermatologist. The result is that sick patients will have to pay more to see the most qualified provider and in turn will be cared for by a very limited number of physicians, consequently worsening access to proper care for the patients who need it the most.

In addition, among dermatologists, tiering and other measurement systems may contribute to an increase in the number of practices no longer accepting insurance or spending more of their clinical time performing cosmetic procedures. Hence, physician tiering may exacerbate the trend in which practices are spending more time and resources on higher-paying patients seeking cosmetic treatments than those seeking an appointment for medical conditions.¹⁶

SUGGESTIONS FOR ACTION BY DERMATOLOGISTS AND HEALTH PLANS

Although performance measurement and tiering remain a source of friction between physicians and

health plans, physicians recognize the political force behind a push for better and more cost-effective care, and constructive steps are already happening. Health plans have been generally accepting of the principles espoused in New York as a result of the legal settlement. Local and national medical societies have become increasingly involved in an advisory capacity with the design of tiering programs. The American Academy of Dermatology is active in this arena.

Dermatologists have good reasons for collaboration with health plans. First, given the rising costs of care and prospects for payment reform, all physicians can expect greater intensity of oversight by health plans, government payers, and the provider organizations to which they belong. The creation of alliances between payers and providers can help avert the imposition of cruder tactics than tiering. Second, collaboration can lead to the development of better measurement tools, which can be used to drive improved patient care. All physicians must be included in the framework of performance measurement and improvement to reach the goal of improving care for everyone.¹⁷

We recommend that dermatologists, through their professional societies, engage with payers as follows: first, help develop and validate a series of evidence-based measures and a practical process for data collection. These should be developed expeditiously, as delays increase the likelihood of unilateral action by payers (especially Medicare). The new measures should be based on data that may be easily collected (from claims, surveys, or some other efficient process).

What might these measures be? One idea is the routine collection of patient outcomes as measured by the Dermatology Life Quality Index (DLQI)¹⁸ or the Physician Global Assessment (PGA).¹⁹ The DLQI is a simple 10-item questionnaire completed by patients that has been used in more than 400 studies worldwide. DLQI scores could be adopted as a standard outcome measure. The PGA is another simple measurement tool, which would require modest additional time by the physician but yield helpful insight into patient outcomes. Another potential measure might be appropriate testing of serum lipids for patients taking isotretinoin, which could be easily tracked from existing claims data. But the important point is that the dermatology community needs to take the lead in the process of identifying relevant measures and the means to collect them.

Health plans must make certain commitments as well. They should provide a complete description of their methods and allow physicians to review data in advance of its release. Additionally, within this

framework of transparency, insurance companies should allow physicians the opportunity to correct any erroneous data and help improve performance indicators. And, as is under way with many payers, they should allow physician input into the development and execution of their methodology.

With healthcare reform on the horizon, the business case for quality and efficiency in health care has never been clearer. However, in the same light, strategic alignment of incentives is needed. This must be a collaborative effort between the payers, providers, and consumers of health care. Payers have a fiduciary duty and dermatologists have a professional responsibility to work toward rapid and continuing improvement. A collaborative performance measurement system that rewards the most efficient physician practices with the highest quality at the lowest cost achieves these aims.

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