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 physicians' performance have evolved.

Once they are in a network or practicing in a certain geographic area, physicians may be rated in a variety of ways by health plans, payers, hospitals or other entities that have some control over their practices or payments. 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 physicians are under development as a way to promote clinical and economic value in health care expenditures. 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 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, policy-makers have moved to regulate how physicians are rated and how that information is presented to consumers. Thus, the potential for legislation that might impede public reporting of physician-quality data is increasingly an area of concern for regional alliances and others with an interest in public reporting.

For instance, in 2006, a physician-rating initiative by a health plan 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, 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 practice might violate New York consumer-protection laws. Negotiations between the attorney general and targeted companies have led to settlements in which companies have promised to follow procedures designed to ensure fairness and accuracy in the rating process. Companies also agree to be overseen by 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 consumers, employers, labor groups, health plans and physician organizations.[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, Colorado enacted a law in 2008 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.

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 of 1986[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. This brief examines Colorado's fair-process law, called the Physician Designation Disclosure Act, in the context of these legal precedents. We focus on Colorado's law because it was one of the first state laws to specifically restrict physician-rating systems and has served as a model for other states that have passed or are considering laws restricting physician rating.

Colorado's Physician Designation Disclosure Act

The Physician Designation Disclosure Act was signed into law on June 3, 2008 and took effect on September 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. Although it uses the term "health care entity" throughout, that term is defined as any carrier or other entity that provides a plan of health care coverage to beneficiaries.[9] Therefore, the law applies only to health plans. However, the procedures mandated for physician-rating systems may affect other organizations, such as regional alliances that work with health plans to develop and publish physician ratings, since the health plan will be limited by law.

Specifically, the Colorado law 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.[10] Any practice guidelines or performance measures used must be endorsed by National Quality Forum or similar organization, a national physician-specialty organization, or the Colorado Clinical Guidelines Collaborative.[11] 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 physician's patient population.[12] 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.[13] Using a physician designation without this disclaimer is a violation of the law.[14]

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 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 for requesting an appeal of the designation decision.[16] The health plan's notice and appeal procedures must give the physician an opportunity to submit corrected data or have it considered, to have the applicability of the methodology considered, to be assisted by a representative, and to have the designation decision explained by whoever is responsible for it.[17] The appeal must be made to someone with the authority to modify the designation decision if it is not fair, reasonable and accurate—and that person must make any such a determination in writing. 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. The law neither specifies how the consideration process on appeal relates to the presumption that physician-submitted data are correct, nor addresses how conflicting data should be reconciled. At the same time, the law requires that a plan ensure the use of accurate data in its designation and presume that the data submitted by physicians is accurate.

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] This means 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 physicians' 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. This means, 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] These provisions may affect a regional alliance if it has state entities as part of its leadership team or partners in its public-reporting program. For example, if a representative of the state health department has a leadership role in an alliance that rates physicians and publicly reports the ratings, or contracts with a third party to rate and report, then that activity could be deemed to be a state action and would be subject to due-process requirements. A physician could sue to stop the rating program as unconstitutional if due process was not provided. A purely private venture with no government participation would not be subject to constitutional due process requirements.

Federal and State Statutes

Although the idea of rating physicians for public-reporting purposes is part of a recent emphasis on "value-based purchasing" and transparency of comparative-performance information to help consumers in decision-making, 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 designating 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[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. The federal law specifies "safe-harbor" procedures that will satisfy its notice and appeal requirements.[25] The law 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 physicians' hospital privileges or physicians' 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 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 federal quality-improvement law, common law principles, or state 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 federal law does not give private physicians a private right of action to sue for damages flowing from an incorrect decision; indeed, the federal law is designed to provide a defense for the decision-makers in the event of such an action, by insulating them from incorrect decisions as long as the process was fair. Thus, were a physician who had received a fair-process review under the federal law 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 were fair. In this regard, the federal quality-improvement law is in a sense the mirror image of the Colorado law. Unlike the Colorado law, the federal one 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 federal law 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. All of these state law examples involve actions by insurers rather than peers; even here, 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 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. It also 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. Essentially, this law favors physicians' privacy interests over transparency in the interest of informed decision-making and patient safety.

In addition the Colorado law breaks new ground by giving individual physicians a right to sue for any violation of the law. Any violation of the law is 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 consumers and payers.

It is important to note that the Colorado law applies only to health insurers or entities that offer health plans and does not appear to apply directly to an independent rating system that secures data from insurers, which may be the situation of regional alliances producing public reports. 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.

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] and the use of electronic health records that have the ability to collect and report quality measures.[34] CMS indicated that "public reporting will play a key role" in the physician value-based purchasing plan it is developing.[35] This federal initiative could result in performance-measurement and public-reporting procedures that, while not preemptive, could be sufficiently different from those permitted in the case of private insurance information to frustrate efforts to move to the CMS-designed system for all payers.

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 working collaboratively with physicians to advance performance measurement efforts, as many communities are, and informing lawmakers about the value of these efforts. Organizations producing reports of physician performance can build fair processes into their performance-measurement systems by including physicians in the process of measure selection, giving physicians notice of their rating, and giving them an opportunity to review the data and correct any errors prior to publication. Fair process may be enforced through contracts, such as data-use agreements, rather than state legislation, which would allow data-collection and reporting practices to adapt to the needs of different organizations and physicians. The necessary elements for fair physician ratings are reasonable systems for presenting data, notice of the rankings, and opportunities to correct errors. These elements can, and should, be built into any physician-rating system.

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[5] The Patient Charter (an initiative of the Consumer-Purchaser Disclosure Project) is available at http://healthcaredisclosure.org/docs/files/PatientCharterDisclosureRelease040108.pdf (accessed September 9, 2009).

[6] Colorado Revised Statutes (C.R.S.) 25-38-102 (2008).

[7] 42 U.S.C. 11101 et seq.

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[10] C.R.S. 25-38-104(1).

[11] C.R.S. 25-38-104(1)(f)(I).

[12] C.R.S. 25-38-104(1)(f)(II).

[13] C.R.S. 25-38-104(2)(a).

[14] C.R.S. 25-38-104(2)(b).

[15] C.R.S. 25-38-105(1).

[16] C.R.S. 25-38-106(1).

[17] C.R.S. 25-38-106(2).

[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. Available at http://www.ncsl.org/statefed/health/AWP.htm (accessed September 9, 2009).

[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).

[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] The American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, 111th Cong., 1st Sess., Sec. 4101(a) (new Section 1848(o)(2)(A) of the Social Security Act (42 U.S.C. 1395w–4) (2009).

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