

Economic Credentialing by Insurance Companies

The Impact of Cost Profiling on Your Practice and Reputation

The Accreditation Council for Graduate Medical Education (ACGME), United Council for Neurologic Subspecialties (UCNS), and the American Board of Psychiatry and Neurology (ABPN) are the three different entities that recognize the 23 different neurology subspecialties. The American Academy of Neurology 2012 position statement defining neurology subspecialties states that any and all subspecialties that are recognized by one of the above three bodies should be considered a separate neurology subspecialty. Unfortunately, when neurologists are profiled by the insurance companies and “rated” on cost efficiency, the “tiers” that appear in the insurance directory do not compare subspecialists to other subspecialists. Neurology subspecialists are compared to their general neurologist colleagues when evaluating the expense of services provided. In some situations, groups of neurology subspecialists have actually been “deselected” by specific insurance companies because the cost of care for patients with particular chronic neurological diseases was higher; often due to the fact that the medications used to treat certain illnesses are expensive. This profiling of physicians based upon their relative expense to the health plan is an example of *Economic Credentialing*.

Physician Economic Credentialing is *Physician Cost Profiling*. This methodology compares the expense incurred by a physician’s patients to the “expected” levels of expenditure. The physician’s relative costs to the health care plan are being used for public reporting. This is the basis of selective or tiered networks. The goals of these initiatives is to lower industry expenditures and give incentives for patients to chose doctors who may offer lower priced care. This type of application requires comparing the market price of care provided by a physician to his or her peers. However, in all specialties, comparing the cost of care rendered by a subspecialist to the care of a physician who is not a subspecialist is not always parallel. Even more compelling, any premium physician who may or

may not be a subspecialist should never be penalized for treating complex chronically ill patients. If appropriate treatment requires providing expensive FDA approved medications, the physician should not be penalized for best care practices. While in objective terms, an attempt of physician credentialing should be a balance between the quality of care provided and other traditional performance measures in addition to cost, there is concern that in the equation of $\text{Value} = \text{Quality} \text{ divided by } \text{Cost}$, the denominator often becomes the driving force as the health care industry attempts to find a better balance between these two standards. If physicians are to be assigned to tiered provider network categories, it is important that the criteria used for selecting doctors based on cost-effectiveness not be the driving force over the quality of care or physician competence.

Economic Credentialing is a generic term that connotes many different types of practices and policies. The insurance industry has adopted this concept and uses it as a way to determine participation in their health care plans. While there is still no reliable evidence to document that economic profiling saves money, placing physicians in tiers suggesting that one is of higher value than another, combined with incentives such as lower copayments, often drives patients to select one physician over another. However, while doctors are currently assigned to tiered provider networks, there remains much concern that the measures used for physician tiering have little relationship to the quality of care or degree of competence. In addition, there is no industry standard or regulated best care practice for physician economic profiling. The metrics generally used for profiling physicians are such that one doctor may have two different tiers from two different insurance companies. While every plan claims that their provider network is the best, there is usually conflicting data from different companies. The American Academy of Neurology has recently become involved in this issue when numerous highly respected Multiple Sclerosis subspecialists were deselected from the provider network of a particular large insurance company. Other highly regarded neurology subspecialists were downgraded from higher tiered designations because they did not meet the cost efficacy of the insurance

provider. While physicians are being rated, tiered and even deselected by large insurance companies, it is impossible to go to the health care plan's Web site and research the process used to create these monetary profiles. The information available does not describe how physician rating is done. This data is consequential and should be available to the medical profession.

Despite lack of transparency, insurance companies argue that physician profiling for tiering purposes does actually include accumulated data that defines a physician's quality scores. However, this concept is not universally accepted by the medical profession. The fact is that it is difficult to acquire documentation that physician profiling and pay for performance metrics are based upon credible data points that accurately measure cost and quality. There has also been overwhelming evidence that suggests the methods used by the insurance industry are not only flawed, unreliable and inaccurate, but are, indeed, significantly weighted toward expense. While most physicians are willing to be held accountable for the quality and cost of care they provide, there has been compelling literature focused on the invalid and discreditable profiling metrics used by industry. Physicians want to be assured that any profile given to them is accurate, trustworthy, and reflects their practice standards. Patients in choosing a physician also deserve the same accurate information.

There is overwhelming evidence that indicates health care purchasers, including the Federal Government, insurance companies and large employers, are pursuing a number of consumer directed policy approaches that depend on cost profiles of individual physicians. This is driven by the fact that physicians have a significant influence on price and value; based upon their fees as well as the diagnostic tests ordered and treatments provided. The passage of health care reform legislation by the 111th Congress is centered on controlling the expense of health care. The system of rating individual physicians based upon economic patterns is a major component of the Patient Protection and Affordable Care Act (ACA). The creation of this type of cost analysis involves multiple factors. The calculations include: (1) the type of care to include in the profile (e.g. acute vs. preventive care); (2) the

costs assigned to each unit of care; (3) the physician responsible for care (e.g. a primary care physician, a specialist, a subspecialist); (4) comparing the type of physician against his/her peers (including specialist vs. subspecialist); (5) the algebra for constructing cost profiles; (6) the process of placing a physician in a low or high cost category; and (7) focusing on individual physicians or physician groups. In addition, patients often see many doctors. In assigning accountability for costs, which doctor should be held accountable for the costs of care? While profiling places a physician on a relative scale of spending, purchasers use the profiles to identify their physician panel. However, without reliable rankings, a physician's reputation could be unnecessarily tarnished resulting in damage to their practice as well as existing trusted doctor-patient relationships. It is imperative that industry demonstrate that the tiering systems they use are reliable and accurate via scientific means before implementing them in their health plans. Unfortunately this is not the current standard. Unreliable rankings and misclassification of physicians have been cited in numerous publications. This includes two excellent studies conducted by RAND Health.

The series of studies by RAND CORPORATION researchers were funded in part by the Department of Labor. RAND is a nonprofit institution that focuses on improving policy and decision making through research and analysis. RAND conducted and published their important classic studies in the March 18, 2010 issue of *The New England Journal of Medicine* and in the May 18, 2010 issue of *Annals of Internal Medicine*. Some of the Key Findings of these studies include the following.

- Between 17 and 61 percent of physicians would be assigned to a different cost category if an attribution rule other than the most common were used.
- Most cost profile scores do not meet common reliability thresholds.
- Reliability of cost profile scores is not clearly linked to the number of care episodes assigned to a physician.
- If common cost profiling methods are used; about 22 percent of physicians would be assigned to the wrong cost category.

- Among the physicians classified as lower cost by profiling tools, 43 percent were not actually lower cost.
- The reliability of cost profiling tools varied by specialty: vascular surgery had the least reliable categorizations while gastroenterology and otolaryngology had the most reliable categorizations.
- A majority (50%) of physicians had cost profiles with reliability under .70, an accepted benchmark for substandard reliability.

At the conclusion of *The New England Journal of Medicine* article it is stated: “These findings bring into question both the utility of cost-profiling tools for high-stakes uses, such as tiered health plan products, and the likelihood that their use will reduce health care spending. Consumers, physicians, and purchasers are all at risk of being misled by the results produced by these tools.”

Multiple criteria, including clinical studies performed by highly reputable organizations such as RAND, indicate that cost profiling of physicians by insurance companies has significant flaws and do not address objective measurements of performance standards. Clearly the goal of controlling the expense of healthcare using economic credentialing cannot be achieved if profile information is inaccurate. The detrimental outcome on inaccurate measures of a physician’s performance can only misrepresent a physician’s practice effectiveness and impugn his/her reputation. Deselecting a physician from an insurance network for unjustified reasons is not acceptable. The results of inaccurate economic profiling of physicians have led to both legal and legislative consequences. A number of state medical societies and legislatures have confronted these issues. The regulatory and statutory rules have resulted in legal challenges to the economic credentialing procedures of different major insurance companies. Many states have enacted legislation that restrict or prohibit economic credentialing. Not all state laws, however, are the same, and most focus on the ability of a hospital to consider economic factors in making credentialing decisions. Other states, such as Texas, do have laws (H.B. No. 1888) that provide required standards for certain rankings by health benefit plans.

In Texas, H.B. No. 1888 gives physicians notice of the ranking metrics; gives physicians due process to challenge a rating, including an appeal; and gives physicians a right to file a complaint with the Texas Department of Insurance. H.B. No. 1888 also requires that the insurance rating systems in Texas use methodology that must be valid. The H.B. No. 1888 rules and regulations are as follows:

Chapter 1652.

Sec. 1460. PHYSICIAN RANKING REQUIREMENTS. (a) A Health benefit plan issuer, including a subsidiary or affiliate, may not rank physicians, classify physician into tiers based on performance, or publish physician-specific information that includes rankings, tiers, ratings, or other comparisons of a physician's performance against standards, measures, or other physicians, unless:

(1) the standards used by the health benefit plan issuer conform to nationally recognized standards and guidelines as required by rules adopted under Section 1460.005;

(2) the standards and measurements to be used by the health benefit plan issuer are disclosed to each affected physician before any evaluation period used by the health benefit plan issuer: and

(3) Each affected physician is afforded, before any publication or other public dissemination, an opportunity to dispute the ranking or classification through a process that, at a minimum, includes due process protections that conform to the following protections:

(A) The health benefit plan issuer provides at least 45 days' written notice to the physician of the proposed rating, ranking, tiering, or comparison, including the methodologies, data, and all other information utilized by the health plan issuer in its rating, tiering, or comparison decision:

(B) In addition to any written fair reconsideration process, the health benefit plan issuer, upon request for review that is made within

30 days of receiving the notice under Paragraph (A), provides a fair reconsideration proceeding, at the physician's option:

(i) by teleconference, at an agreed upon time: or

(ii) in person, at an agreed time or between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday:

(C) the physician has the right to provide information at a requested fair reconsideration proceeding for determination by a decision-maker, have a representative participated in the fair reconsideration proceeding, and submit written statement at the conclusion of the fair reconsideration proceeding: and

(D) the health benefit plan issuer provides a written communication of the outcome of a fair reconsideration proceeding prior to any publication or dissemination of the rating, ranking, tiering, or comparison. The written communication must include the specific reasons for the final decision

(b) This section does not apply to the publication of a list of network physicians and providers if ratings or comparisons are not made and the list is not a product of nor reflects the tiering or classification of physicians or providers

Economic Credentialing and tiering by insurance companies must be more accurate and include measurements of the physician's qualifications, clinical performance, reputation for excellence, and overall competency. Rating physicians should be based upon lateral comparisons between non-specialists, specialists, and subspecialists. Patients also need to be informed that physician evaluations and tiering based primarily on cost criteria may have a high risk of error. Most patients would be more interested in a physician's quality scores as opposed to paramount reliance on cost criteria without quality measurements.

Stuart B Black MD, FAAN

