GENERAL GUIDANCE FOR PUBLICLY REPORTING PHYSICIAN QUALITY INFORMATION

The following recommendations, derived from workgroup discussions with Vermont insurers and the Vermont Medical Society, summarize the Department's guidance on insurer reporting of physician quality information (for PCPs or other specialty physicians) as required under Rule H-2007-05.

1. **Use of nationally recognized physician quality information standards**. For compliance with Rule H-2007-05, insurers should use nationally recognized standards for reporting physician quality information, such as NCQA's PHQ-1 Standards. These standards require a certain percentage of the quality measures used for reporting to be endorsed by either the National Quality Forum (NQF) or the Ambulatory Quality Alliance (AQA), and they have been approved by the New York Attorney General.

2. **Use of nationally recognized and approved clinical measures to report physician quality information.** Rule H-2007-05 requires that the quality measures used for public reporting in Vermont be "approved by the Commissioner, after consultation with affected parties, as valid and reliable, or designated as 'nationally recognized' by the Commissioner, after consultation with affected parties." The Rule outlines sources of nationally recognized measures, including the Centers for Medicare and Medicaid Services, NQF, and AQA. In addition, as noted above, NCQA's PHQ-1 Standards require a certain percentage of the measures to be NQF or AQA endorsed. Insurers should review the most recent version of the CMS PQRI measures at least annually to assess whether their quality measures used for public reporting in Vermont can be drawn from PQRI measures, in order to coordinate national and state reporting initiatives.

3. **Solo practitioner reporting.** The Department recommends that insurers report practice-level results in 2011 in response to small numbers issues and the fact that public reporting of physician quality information is a relatively recent initiative. In general, insurers should not publicly report results with denominators of less than 30, nor should they report results for solo practitioners for the January 2011 consumer information plans. However, solo practitioners may voluntarily opt-in to participate in an insurer's public reporting of physician quality information for consumers.

4. **Attribution of physicians to practices.** Insurers should consider asking physicians to self-assign to a practice when they are affiliated with more than one practice. An alternative methodology of attributing physicians to practices is to use tax identification numbers.

5. **Attribution of patients to physicians.** Some primary care quality measures attribute patients to diagnosing physicians. Other primary care quality measures rely on the identification of a primary care physician, which can be achieved by

member selection of a primary care physician or a certain number of visits to the physician by the patient. Specialist quality measures generally attribute patients based on visits to the specialist. Regardless of the method of attribution, insurers' approaches should be completely transparent to members and physicians.

6. **Data collection time periods.** The Department recommends that insurers consider using multiple years of data to increase denominator sizes, if there is a need to identify additional high-volume practices.

7. **Sharing results with physicians prior to public reporting.** Section 4(e)12 of Rule H-2007-05 requires insurers to "establish a procedure for Health Care Providers to review the Price and quality information related to the Health Care Provider, and to comment on its accuracy." Section 5.3(E) of Rule H-2009-03 requires insurers to "establish a procedure that permits health care providers to review their own results on performance measures intended for public reporting in advance of their release." The Department strongly recommends that physicians be provided at least 45 days to review results prior to public reporting.

8. **Information provided to physicians prior to public reporting.** At a minimum, physicians must be provided with their results (practice level and physician level, if available) as they will be depicted on the insurer's website. In addition, physicians should be provided with as much available detail as they request on the data behind the results.

9. **Process for handling physician requests for corrections.** Section 4(e)12 of Rule H-2007-05 requires insurers to "promptly correct inaccuracies where warranted." Section 5.3(E) of Rule H-2009-03 requires insurers to "include a reasonable opportunity for a provider to request correction of any inaccuracies prior to publication of the data and reasonable procedures and time limits for resolving disputes."

10. **Data validation processes.** Physicians should be provided with as much available information about patients identified as not receiving the recommended care as they request, so that they can validate the data. Section 5.3(E) of Rule H-2009-03 states: "If the performance measures are derived from claims data without any medical record review, the managed care organization, if requested by the provider, shall confirm those results with a review of medical records prior to public reporting." The Department recommends that insurers conduct chart reviews at the physician's office, if requested by the physician.

11. **Ranking systems.** The Department anticipates that insurers will develop their own methods for presenting the results. Symbols and/or numbers may be used.

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12. **Physician access to quality information reported to members.** Physicians should have access to quality information reported by insurers to members.

13. **Availability of measurement methodology to physicians and consumers.** Insurers should provide physicians and members with access to the measurement methodology. The methodology behind the data should be completely transparent.

14. **Administrative burdens on providers**. Section 6.2(F) of Rule H-2009-03 requires managed care organizations to consult with contracted providers to develop and implement a satisfactory process to minimize the administrative burdens on providers (especially for those providers in small group practices) of implementing the quality improvement activities required in Sections 6.3(B)7 and 6.3(B)8. If managed care organizations intend to use the reporting of physician quality information to their members under Rule H-2007-05 in an effort to meet the requirement of "motivating… high-volume provider efforts to generate quality improvement…," to use as a process to "promote accountability," or to meet any other requirement in Sections 6.3(B)7 or 6.3(B)8, they must meet the requirements of Section 6.2(F) of Rule 9-03.

    In evaluating compliance with 6.2(F), the Department would expect to see evidence that managed care organizations proactively consulted with contracted providers, including providers in small group practices, and used input from that consultation to "develop and implement a satisfactory process to minimize the administrative burdens on providers."

    It is the Department's recommendation that the same consultation occur between insurers and contracted providers for the purposes of insurer reporting of quality information to members under Rule H-2007-05, regardless of whether the reporting is to be used to meet any of the requirements in Sections 6.3(B)7 or 6.3(B)8.

15. **Incentives for members to use specific contracted providers.** Section 6.3(A) of Rule H-2009-03 states that "The use of quality management program data to design incentives for members to use specific contracted providers shall not be implemented without Department approval and shall not reduce the member benefits otherwise applicable." If the quality measures for public reporting under H-2007-05 are being used to design financial incentives for members to use specific contracted providers, this requirement would apply.