

**REPORT TO THE BOARD OF TRUSTEES
AND KEITH BOURGEOIS, M. D., CHAIR, COUNCIL ON SOCIOECONOMICS
BY THE AD HOC COMMITTEE ON BLUECHOICE SOLUTIONS/RACI**

Ad Hoc Committee on BlueChoice Solutions/Risk Adjusted Cost Index (RACI)

Charge: To fairly profile the “affordability” component of physician practices in the BlueChoice Solutions (BCS) network. This includes suggesting substantial modifications or potential elimination of the BCS Risk Adjusted Cost Index (RACI) methodology to avoid outright economic credentialing in the BCS network.

Objective: To empanel a small ad hoc committee with expertise in physician rating systems, statistics and analysis to evaluate the BCBS-TX RACI, examining the issues of clinical attribution, accurate comparisons to peers and expense of admitting/treating facilities. To also reach an overall conclusion about the validity and accuracy of the RACI methodology for use in credentialing physicians and as a physician “affordability” rating system.

Plan: This group of physicians known as the “TMA Ad Hoc Committee on BlueChoice Solutions/RACI” will meet via conference call for the first quarter of '08 and will report its progress to the Chair of the TMA Council on Socioeconomics. Members from the Councils on Socioeconomics/Scientific Affairs, Patient-Physician Advocacy Committee and a county medical society representative will be selected. The recommendations and conclusions of the Committee will be reported to the Board of Trustees and Council on Socioeconomics during May, 2008 meetings of both bodies.

Initially, TMA staff will identify key problems with the RACI and supply relevant research and information. For example, the Ad Hoc Committee will examine problems with sole reliance on and use of claims data and related issues. This preliminary document will be shared with the physicians on the committee at its first meeting.

Resources: Staff from the Divisions of Medical Economics, Public Health and Medical Education, Public Affairs and the Office of the General Counsel will be involved to fully evaluate and lend expertise to clinical, coding/billing, data reporting, and legal dimensions of the RACI. Additionally, Bill Taylor, MD MPH, from Blue Cross will be asked to present to the Ad Hoc Committee. BCBS-TX will be asked to provide information on their “affordability” RACI rating systems as part of Dr Taylor’s presentation.

Committee Members: Members of the ad hoc committee will be appointed by Dr. Bourgeois, Chair, Council on Socioeconomics, following confirmation of their willingness to serve.

Ad Hoc Committee on BlueChoice Solutions/RACI

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**2008 Timetable for
Ad Hoc Committee on BlueChoice Solutions/RACI Deliberations**

February 19, 2008

Initial Organizational Conference Call of the Ad Hoc Committee

1. Dissemination of Background Material, Discussion: Distributed Documents
2. Briefing re: Inquiry of the Texas Attorney General-Blue Choice Solutions
3. Update on related issues:
 - a. BCBS Advisory Committee on Measures of Performance Update
 - b. BCS Network Update

March 5, 2008

2nd Meeting/Call of the Ad Hoc Committee

1. Webinar with Dr. Bill Taylor, BCBS-TX in-depth presentation: BCS/RACI
2. Discussion, Questions from Committee members, TMA staff

March 25, 2008

3rd Meeting/Call of the Ad Hoc Committee

1. Draft recommendation summaries presented for Committee Review
2. Discussion, deliberation re: draft recommendations
3. Feedback for further drafting recommendations and vetting.

April 22, 2008

4th Meeting/Call of the Ad Hoc Committee

1. Close on recommendations and ask for final Committee feedback and related edits
2. Close on drafting a report for the Board of Trustees and the C on SE

May 1, 2008

Report to Board of Trustees; review and adoption by C on SE

1. Report is reviewed by the Board of Trustees and adopted by C on SE
2. Ad Hoc Committee is discharged

TMA Framework for Evaluation of Physician Performance Rating Programs
Speer Report to the Board of Trustees, 2006

- Is there a willingness to appoint an expert team of TMA members to review clinical measures with input on the rating program and physician communications?
- Has the performance rating methodology been externally and objectively validated?
- Is there an option for a pilot testing of the program in a selected market to evaluate results and make modifications as appropriate?
- Is there an “opt out” option for physicians who do not wish to participate in the rating program?
- To assure transparency, will physicians be able to obtain the data on which they are rated?
- Will there be a robust, timely review and appeals process?
- Are communication materials for patients written at an 8th grade level to address health literacy issues?
- Will there be timely updates on rating metrics that are made available to the public (i.e. changes in star, ribbon, etc icons on the plan website)

Discussion, Recommendations and Conclusions

1. PROBLEMS: RISK ADJUSTED COST ASSIGNMENT, “EPISODE OF CARE” CONSTRUCTION/ATTRIBUTION

Discussion. TMA continues to receive reports of significant problems with costs that are inaccurately and/or unfairly attributed to physicians caring for BCS patients. Although a methodology that uses claims data to assign risk and severity scores to individual patients generally rests on sound methodological ground, the “affordability” rating process used by BCBS to assign responsibility for *costs* of care to physicians relies on untested techniques that to date have not been externally and objectively validated. The BCS risk adjusted cost index method (RACI) arbitrarily penalizes physicians for costs over which they clearly have no control. Physicians are rated by an arcane and redundant cost-assignment system that is opaque to both patients and practicing physicians. The assumptions made in the cost-assignment system involve arbitrarily constructed clinically imprecise “episodes of care”, which may falsely attribute care costs to a particular physician. That physician may not have been responsible for generating the majority of the services that produced the costs. Examples would be imaging and/or lab tests ordered by other physicians, or a patient’s decision to pursue an emergency department visit in lieu of scheduling a physician office/medical home visit. When more than one physician is involved in the care of a complicated patient with multiple co-morbidities it often becomes virtually impossible to appropriately assign the costs of care to a single physician. The BCS RACI, however, does exactly that.

For patients determination of their physician’s “affordability” is confusing and deceptive as a representation of both their physicians’ service costs and how those physicians make health care decisions on their behalf. TMA has received numerous reports from physicians that the BCS RACI method for attributing episodic costs frequently misrepresents the cost and, by extension, the quality of the care they provide for patients.

This difficulty is described in some detail in a large study of Medicare patients published in the *New England Journal of Medicine* in 2007, in which caution was urged in the use of such attribution schemes, given that the patients as study subjects saw a median of two primary care doctors and five specialists in four different practices over a two year period. The NEJM data serve as a red flag that methodologies of the type described above are flawed both in constructing “episodes of care” and in assignment of risk adjusted costs overall.

RECOMMENDATION: The current method for “actual cost” assignment used by BlueChoice Solutions to determine a physician’s risk adjusted cost index is seriously flawed, is not scientifically validated and should not be used as a relative measure of “affordability” (a term used as BCBS-TX’s synonym for physician-generated service costs in the economic credentialing of physicians in the BlueChoice Solutions network). This method is clearly inappropriate for credentialing physicians in any network or for use as the basis for any comparative rating system. The term “affordability” is applied in an invalid and misleading fashion in both credentialing and rating of physicians by BCBS-TX

and in the company’s representations to employers and patients about the risk adjusted, episodic costs of physician services. It should not be used as a definitional or descriptive term in the company’s information about the BCS plan.

2. CLAIMS CODING/PROCESSING ISSUES

Discussion. Appropriate, accurate diagnostic coding by physicians and their coding staffs is key to the ultimate processing and disposition of BCBS claims for performed services. Physicians face many challenges to optimally perform diagnostic coding functions required to submit claims for any health plan’s covered services. However there is also a serious question about the capacity of BCBS to receive electronic or paper submissions with all of the coding information necessary to fairly and completely process BCS claims. These capacity concerns threaten the integrity of transactions in the network and the viability of the network itself. Beyond the operational and educational challenges TMA faces in assisting member physicians, a number of unanswered questions remains about the specific ability of BCBS-TX to receive and process both electronically and manually submitted BCS claims. A network analytics official of the company has told the Ad Hoc Committee on BCBS-TX Solutions/RACI that there are “questions” about both the BCBS system capacity to appropriately accept the maximum number of diagnostic codes on submitted claim formats (electronically or manually submitted), and to appropriately and accurately process those claims following receipt. Those questions remain unanswered despite TMA expressions of concern, and additional information and data recently provided by BCBS-TX. For all concerned this is a crucial issue that deserves the prompt attention of BCBS-TX, since an important root cause of the problems with the BCS claims database is inaccurate and/or incomplete data generated from the claims coding and processing systems of BCBS-TX.

RECOMMENDATION: That these BCBS-TX claims coding and related claims processing system problems should be immediately addressed and resolved by BCBS-TX to meet at a minimum their regulatory and contractual obligations to patients, employers and contracted physicians to accept and process BlueChoice Solutions claims, and to provide more accurate data for credentialing and performance rating decisions that are in part dependent on coding and related processing information from those claims.

3. TRANSPARENCY ISSUES

Discussion. Physicians who are eligible for BCS are significantly disadvantaged by the lack of cost of service transparency in the BCS network. In particular, facility related service costs of contracted hospitals and other facilities are not known nor controlled by BCS network physicians. Important information related to covered BCS benefits and related patient service costs outside physicians’ offices is generally not available nor disclosed to participating and/or billing physicians. Since BCBS-TX credentials its BCS network physicians to be “affordable” in providing services and to refer and steer patients to other

“affordable” venues, it is imperative that all relevant cost of service information be disclosed to network physicians by BCBS-TX. Such information should include all relevant service provision costs in any inpatient, ambulatory, diagnostic or surgical facility with which a network physician interacts on behalf of a patient/enrollee.

RECOMMENDATION: That all relevant cost of service attribution and covered benefit information affecting BCS network physicians’ service and referral decisions for patients/enrollees should be fully transparent, available and disclosed to those physicians and patients in all applicable, covered settings of care. The Council on Socioeconomics should also identify the potential impacts on patients and their physicians that such disclosure and transparency would have in terms of BCS network services, physician participation and patient referrals, and share that information with appropriate regulatory public policy and other elected officials.

4. DUE PROCESS ISSUES

Discussion. Physicians pursuing appeals or trying to find information about options for challenging their RACI data or network eligibility determinations continue to contact TMA for assistance. While some information is available on the BCS website and through recently enhanced TMA resources, clear and unambiguous information that describes the appeal process options for physicians in this regard is not easily accessible to physicians, their offices and patients. This problem constitutes a serious problem challenging both the credibility and integrity of BCS. In addition, local company provider service representatives sometimes give conflicting, incomplete or inaccurate information to BCS network physicians/their practice staffs about how to pursue available due process remedies, and the distinctions between requesting disputed BCBS-TX data about their BCS RACI scores and actually commencing a formal appeal. Information in this regard is often obscured, usually to the detriment of physicians. As a result, many physicians notified they were ineligible for participation in the BCS network were under the misimpression that their request to additional information to examine the data behind their RACI scores was the same as asking for a review. Their efforts to discuss and have their BCS RACI data reviewed by BCBS-TX actually may not have been treated by BCBS as a formal appeal.

The process itself for review of adverse RACI ratings is inadequate. Being declared ineligible for a network based on not being “affordable” is an insult to the rated physicians and adversely affects the patient-physician relationship. Due process protections should be provided, including the minimum requirements set forth in the federal Health Care Quality Improvement Act and its implementing regulations. When physicians are being judged on their “professional conduct,” e.g., quality or cost factors, due process should be provided before adverse action is taken. (See Code of Medical Ethics of the AMA, CEJA opinion 9.05. A “fair hearing,” an essential element to a fair process, before colleagues of the same or similar specialty is not available in the current BCS process).

RECOMMENDATION: That BCBS-TX substantially improve and make transparent all due process options as provided in the Health Care Quality Improvement Act and implementing regulations prior to any publication or action based on measuring physician professional conduct.

5. VALIDITY OF RISK ADJUSTED COST SCORING METHODS

Discussion. There are now scholarly articles including those developed at the University of South Maine's Institute for Health Policy at the Muskie School of Public Service and the New England Journal of Medicine that have raised serious questions about both the methodological soundness and efficacy of risk adjusted cost scoring and rating systems at the individual level. In the absence of systematic integration of care settings and services, individual level performance assessment is highly problematic and frequently misleading to physicians, patients, policy makers and major purchasers. Additionally, the lack of widely accepted, independently validated methods for determining how risk and severity adjusted costs are assigned to episodes of care make it impossible at this point in time to devise consistently accurate and fair performance assessment systems at both individual and group levels. The BCS approach to assignment of costs seems to be driven by a result oriented approach to discover a method whereby the majority of episodes *can be* assigned to a physician rather than to discover a method whereby the majority of episodes *can be accurately* assigned to a physician (which may not be possible according to the studies referenced earlier).

OVERALL CONCLUSION: That BCBS-TX does not, in its BlueChoice Solutions plan, use an accurate or independently validated method for determining risk adjusted costs at the individual performance level, and that the other deficits noted in this report essentially render the method deceptive and invalid for credentialing and related performance assessment purposes at both individual and group physician performance levels as well.

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Research, Reference and Information List

- “Insurer Sponsored Rating Systems”, report to the Board of Trustees, February, 2008.
- “Select Committee on Physician Performance”, TMA report to the Board of Trustees, January, 2007.
- “Economic Profiling of Physicians: What is it? How is it done? What are the Issues?” J.W. Thomas, Ph.D., Institute for Health Policy, Muskie School of Public Service, University of Southern Maine, June, 2006.
- “Rating Physicians-A Comparative Look at Health Plan Methodologies, Presentation to TMA Fall Conference, Physicians Advocacy Institute, Inc., slides furnished by permission, Mary Jo Malone, CEO, October, 2007
- “Guidelines for Measuring, Reporting and Rewarding Physician Performance”, Massachusetts Medical Society, 2005.
- “Review of the Massachusetts Group Insurance Commission Physician Profiling and Network Tiering Plan”, A report to the Massachusetts Medical Society, Robert A. Greene, M.D. et al, Focused Medical Analytics, Inc. and the University of Southern Maine, June, 2006
- “Understanding Episodes of Care”, research document and presentation of the Physicians Advocacy Institute, Greene et al, Chicago, Illinois, 2006
- “Measures of Performance”, webinar slide presentation to BCBS-TX Advisory Committee on Measures of Performance, William J. Taylor, M. D., MPH, Medical Director, Network Analytics, slides also furnished by permission, BCBS-TX, May, 2007
- “Care Patterns in Medicare and their Implications for Pay for Performance”, Pham et al., *New England Journal of Medicine*, March, 2007
- “Paying for Care Episodes and Care Coordination”, Karen Davis, Ph.D., *New England Journal of Medicine*, March 2007
- “Pay for Performance Programs in Family Practices in the United Kingdom”, Doran et al., *New England Journal of Medicine*, July, 2006
- “BlueChoice Solutions Appeal Process”, as revised, flow diagram and descriptors, BCBS-TX, Richardson TX, 2008