

For Immediate Release  
April 23, 2010

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Andrew LaMar

## **CMA Pulls out of Doctor Rating Initiative, Slams Blue Shield for Misleading Patients With Faulty Data**

*Blue Shield's ratings will confuse patients, raise healthcare costs and irreparably harm physicians' reputations by using a defective reporting system*

**Sacramento** – The California Medical Association has withdrawn from a Blue Shield-led initiative to rate doctor performances because the insurer intends to move forward with publishing its ratings on June 1 despite serious and disturbing flaws in how data is collected on physicians that result in gross inaccuracies.

“Publishing erroneous information will only serve to confuse patients, increase costs and unjustly destroy the reputations of many fine doctors,” said Brennan Cassidy, MD, president of CMA. “We are happy to stand on the merits of our work, as long as it is assessed accurately and fairly, but this initiative is far, far short of achieving that goal. As physicians, we are proud of the work we do healing patients each and every day.”

CMA worked for two years on the California Physician Performance Initiative (CCPI) with other stakeholders but pulled out last week when it became clear Blue Shield of California planned to ignore doctors' input and publish rating data before fixing fundamental flaws in performance assessment.

In a letter dated April 15 (below) that informed CPPI of its withdrawal, CMA said major problems include:

- Confusion for patients, who may be unduly concerned if their physicians do not get a high rating or may be tempted to select a new doctor who has a high rating. Because the ratings will not be an accurate assessment of doctors' performances, it will cause unnecessary confusion and anxiety for patients.
- More costs for payers and patients. To receive high ratings, physicians will have to compensate for flaws in the reporting system, meaning some may have to order tests or procedures that have already been done but are not captured in claims data.
- Lack of sensible adjustments for other major factors affecting the patient. For instance, physicians who don't order cervical cancer screening tests for their patients, even if the patients have already had hysterectomies, would get a lower rating.
- Lack of relevant data collection. The ratings only capture patient data for physicians contracting with the insurer, but for a variety of reasons, patients may need to see a physician not affiliated with the health plan's network. None of the out-of-network care is reflected. For instance, in a Preferred Provider

Organization (PPO) setting, a patient may see an out-of-network, non-contracting OBGYN for a pap smear and may not inform her regular in-network primary care physician of it. Under CPPI rules, the primary care physician would be penalized because there would be no pap smear claims data submitted to the health plan.

- No consideration of the patient's role. The ratings do not take into account, at all, patient refusal of treatment. For instance, patients may opt not to have a procedure or treatment done because they are unemployed and have lost their health insurance, want to go against the doctor's recommendation or have other extenuating circumstances.

"We have worked in good faith with Blue Shield of California and the California Physician Performance Initiative," Cassidy said. "Unfortunately, the initiative's governing board, which is dominated by insurers, has chosen to ignore physicians' grave concerns about this inaccurate rating system. Blue Shield's ratings are defective and Blue Shield is exercising poor judgment to publish them."

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*The California Medical Association represents more than 35,000 physicians in all modes of practice and specialties. CMA is dedicated to the health of all patients in California.*

April 15, 2010

Blue Shield of California  
Attention: Bruce Bodaken, President & CEO  
Blue Shield of California Corporate Headquarters  
50 Beale Street, San Francisco, CA 94105-1808

The California Cooperative  
Healthcare Reporting Initiative  
c/o Pacific Business Group on Health  
Attention: David Lansky, CEO  
221 Main Street, Suite 1500 San Francisco, CA 94105

**RE: CALIFORNIA PHYSICIAN PERFORMANCE INITIATIVE**

Dear Messrs: Bodaken and Lansky

On behalf of the California Medical Association (CMA), I am writing to inform you that, effective immediately, we hereby terminate our participation with the California Physician Performance Initiative. We do so because we are deeply disturbed by the process and by Blue Shield of California's insistence to move forward with publishing faulty data that will only serve to mislead patients and irreparably harm physicians' personal and professional reputation. What follows is the basis for our decision via policies adopted by our Board of Trustees (BOT).

As you may know, CMA's process to further review CPPI included establishment of a Quality Technical Advisory Committee (QTAC). Members of the QTAC included CMA physicians representing a wide variety of physician perspectives. Physicians in large group and solo practices who have dedicated large portions of their careers to improving the quality of care delivered in California participated in this process.

After three meetings, one with Pacific Business Group on Health (PBGH) and Blue Shield, *the committee concluded that the goal and rationale of CPPI are inconsistent with the CPPI product.* The QTAC concluded that many significant and unresolved issues remain, and that the CPPI product is a work in progress. *Further, the QTAC has concluded that publication of the CPPI at this time will do more harm than good to California's collective health care community—patients, physicians, and payors.*

As discussed below, these significant and unresolved issues include, but are not limited to, the following:

**1) Inaccurate financial claims data used by insurers for the CPPI may mislead patients in choosing or retaining physicians, irreparably harm a physician's professional and personal reputation, and may not necessarily address payor concerns about costs.**

Claims data is set up for billing, and not for quality measurement. One of the intended goals of CPPI is to provide patients with accurate information when choosing or retaining physicians because public websites (e.g., Yelp) and word-of-mouth referrals are unreliable. Based on the experience of physicians with the CPPI and QTAC's careful review of the CPPI, the QTAC concluded that the CPPI will not necessarily present more accurate information to patients because the claims data used are inherently flawed. Indeed, the CPPI branding and messaging may be different from Yelp, but the end result will likely be the same—unreliable information to patients.

**2) Inadequate consideration of patient adherence to recommended physician care may also discourage physicians to continue seeing non-compliant patients to avoid negative CPPI scores(1).** Under the current CPPI model, physicians are 100% accountable even if a patient refuses to adhere to recommended care. There are strong sentiments from physicians that they should not be penalized for something that is beyond their control as submitted by physicians who participated in the CPPI. For example, one physician declined to pursue recommending a colonoscopy to his bed-ridden dying patient; 2) another patient delayed a recommended procedure because she lost her job; 3) some patients may forgo recommended care because they are on vacation, out of the country, or they dropped their health coverage; and 4) other patients by choice may simply refuse to adhere to certain procedures (like colonoscopy). In sum, CPPI fails to adjust for patient behavior. This may have the unintended consequence of creating a disincentive to care for non-compliant patients to avert negative CPPI scores.

**3) Incorrect patient attribution dilutes the quality of care the physician provided to a patient, and is inefficient because it may actually lead to duplicative care.** For instance, in a Preferred Provider Organization (PPO) setting, a patient may see an out-of-network, non-contracting OBGYN for a pap smear, and that patient may not inform her regular in-network, contracting primary care physician about the pap smear. Under the current CPPI rules, the in-network physician is attributed the patient and is penalized because there are no pap smear claims data submitted to the health plan. Also, the out-of-network, non-contracting physician will not receive the credit because he has no contract with the payor. This example is troubling because it may compel the primary care physician to order another pap smear to avoid receiving a low CPPI score. Duplicative care is contrary to the efforts of payors to control the cost of healthcare.

**4) Inappropriate use of quality metrics and inclusion of problematic measures.** Physicians are particularly concerned with the lack of efficacy of the quality measurements used by CPPI. These measures do not capture patient outcomes and offer only a cursory view of the overall care provided by a physician. *To quote the Journal of American of Medical Association, "[by] relying on highly focused quality metrics one at a time [which CPPI does], [we] are viewing care through a tiny keyhole.*(2) Furthermore, although CPPI committed to exclude colonoscopy and heart failure from CPPI in cycle 4 because of the many flaws associated with such measures, there is lingering concern about other measures that remain problematic. For example, physicians were penalized for not recommending cervical cancer screening tests to patients who had undergone hysterectomies.

**5) Insufficient patient sample size remains unresolved.** The CPPI uses insurer commercial data from Anthem Blue Cross, Blue Shield, and United Health Care. It excludes administrative services only (ASO) data, public payor data from Medi-Cal and Medicare, and other private carriers like Aetna and Cigna. Thus, many physicians remain skeptical that CPPI has enough patients in any specific group to support statistically valid measurement. It is important to note that the Journal of American Medical Association article discussed in the previous bullet above raised a similar concern.

**6) Imbalanced CPPI governance structure.** While physicians may have a voice in CPPI's Physician Advisory Group, their recommendations are often set aside or overturned by CPPI's Executive Committee, which is dominated by payor representatives. This imbalance is contrary to the collaborative process CPPI agreed to follow.

**7) Ineffectiveness of insurer/payor physician rating programs like the CPPI.** Some physicians view ratings to be unproductive because they are judgmental, motivate through blame and fear, and engender adversarial relationships rather than effectively engage practitioners in change(3). Indeed, a recent New England Journal of Medicine article concluded the following statement about physician ratings generally: *"Consumers, physicians, and purchasers are all at risk of being misled by the results produced by these tools.*(4)"

In light of the many significant and unresolved issues with the CPPI, the CMA BOT adopted policies that would address the issue of providing accurate information to patients, payor concerns about costs, and publication of misleading information.

These policies acknowledge that patients need more accurate information on quality and costs when choosing or retaining physician. They encourage CMA to work with all relevant parties to develop a program, set of information, or system that will help patients choose or retain their physicians in an accurate, reliable, reasonable, and useful manner. Furthermore, these policies encourage all stakeholders—including payors—to provide appropriate incentives for patients or employees to follow healthier, modifiable behaviors and adhere to physician recommended treatments and/or screening/prevention guidelines. They also state that physicians should not be

held accountable for the patient's informed decision to not participate in physician recommended treatments and/or screening/prevention guidelines. The CMA BOT also supported policies that would allow CMA to collaborate with payors on an alternative quality initiative program that would motivate and engage physicians to improve patient care and performance, and address payor concerns about costs without the shortcomings or judgmental features associated with insurer/payor physician public rating programs.

As to the issue of Blue Shield's pending publication of the CPPI product, the CMA BOT instructed CMA to communicate to CPPI and all relevant stakeholders in the strongest terms possible that publication of the CPPI without addressing significant concerns raised by CMA, local medical societies, and other physician groups forces CMA to withdraw from CPPI participation. CMA cannot lend credence to nor continue to participate in a flawed quality initiative program that would mislead patients, irreparably harm reputations of physicians, and fail to address payor concerns about costs. Publication of CPPI in its current form further compels CMA to explore and pursue all appropriate courses of action necessary to protect its physician members and their patients from publication of misleading physician rating information. In sum, the CMA BOT concluded that, in light of the many, significant, and unresolved issues with the CPPI, the CPPI should be voluntary and physicians should be given the opportunity to affirmatively opt out of the CPPI moving forward.

Based on the feedback from our physician members, we have made a good faith effort to collaborate on a quality initiative that offers reliable and accurate information. It is important to emphasize that CMA remains committed to working with payors on a quality initiative other than the CPPI. We recognize that CPPI and Blue Shield attempted to address some of our concerns in the past couple of months as reflected on PBGH's letter dated March 29, 2010. In truth, however, the adjustments made are inadequate to address the more fundamental issues we have raised. Furthermore, we think that there is little incentive for Blue Shield or other insurers to address these issues once the CPPI is published in its current form.

It is now apparent to our physician members that Blue Shield intends to publish the CPPI product notwithstanding the many significant and unresolved issues we have raised. Such action compels CMA to disengage from CPPI. We no longer believe our involvement would be worthwhile and cannot associate ourselves with a deeply flawed project that misleads patients and falsely disparages physicians. Accordingly, effective immediately, CMA hereby terminates our involvement and participation on the Physician Advisory Group, Executive Committee, and with CPPI in all manner generally. We request that you immediately cease mentioning or identifying CMA in any way as a supporter or participant of, or in association with, CPPI. Please contact me at (916) 444-5532 if you would like to further discuss these issues.

Sincerely,

Dustin Corcoran  
Chief Executive Officer

#### FOOTNOTES

(1) CMA recognizes that CPPI included patient adherence to a recommended physician procedure in cycle 4, but it has since decided that such consideration will be excluded moving forward. (2) Journal of American Medical Association: "Measuring Physicians' Quality and Performance." (December 2009) (3) Health Affairs: "Beyond the Efficiency Index: Finding a Better Way to Reduce Overuse and Increase Efficiency in Physician Care." (May 2008) (4) New England Journal of Medicine: "Physician Cost Profiling—Reliability and Risk of Misclassification." (March 2010)