



Forum Session Meeting Announcement

Friday, July 13, 2007
9:00am — Breakfast
9:30–11:30am — Session

What Can Physician Profiling Do for Medicare?

A Discussion Featuring:

A. Bruce Steinwald
Director, Health Policy
Government Accountability Office

Eric Nielsen, MD
Chief Medical Officer
Greater Rochester Independent Practice Association

Dale Magee, MD
President
Massachusetts Medical Society

Location

**Reserve Officers Association
of the United States**
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
*(Across from the Dirksen Senate
Office Building)*

Registration Required

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as soon as possible.

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What Can Physician Profiling Do for Medicare?

OVERVIEW

This meeting will explore the feasibility and utility of physician profiling in the Medicare program to address rising spending. Profiling, that is, comparing the average resource use of a physician's patients to the resource use of other physicians' patients, has been examined by the Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC). Although they used different methods, both organizations identified wide variation in the efficiency with which physicians deliver care. Based on its analyses and interviews with private payers, GAO recommended that Medicare adopt physician profiling techniques. This Forum session will focus on GAO's recent report and how a profiling approach could help to address Medicare's fiscal problems. In addition, one physician will document how his provider group has used profiling to improve quality of care, and another physician will present information about the use of profiling and concerns about the accuracy of physician comparisons.

SESSION

The search continues for ways to control Medicare spending and for a solution to the related sustainable growth rate (SGR) problem. The SGR is Medicare's method for controlling physician spending: the annual update to fees is reduced if spending is above a predetermined target and it is increased if spending is below the target. The SGR has been roundly criticized for being a blunt instrument because it fails to distinguish between spending for beneficial services and spending for marginal ones and it fails to distinguish between fees paid to frugal physicians and fees to profligate physicians. Further, the SGR hasn't worked. Between 1996 and 2006, cumulative Medicare spending on physician services was over \$40 billion more than allowed under the SGR system because of increases in the volume and intensity of physician services. The Congress bypassed the SGR-determined updates for each of the last five years, however, because of concerns about potential physician response to lower Medicare fees.

The problem of how to slow physician spending growth is still on the table. A recent analysis by the Congressional Budget Office supports earlier studies that indicate that the volume and intensity of physicians' services, not the fee paid for each service, has caused the rise in Medicare physician spending.¹ Although Medicare can set the fee for each service, controlling the volume and intensity of physician care has remained elusive.

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Private Efforts to Alter Physician Practice Patterns

Some health plans have tried to harness the often large differences in practice patterns across physicians to hold down spending, either by steering patients to low-spending physicians or by excluding high-spending physicians from their networks. Plans have also tried to encourage lower cost practice styles by providing information to physicians about the variation in resource use for similar patients across physicians and how a particular physician's practice profile compares with that of others. Public reporting of efficiency measures and differential patient co-payments has also been used to influence patient choice of providers.

From a different angle, provider groups have used profiling to control or reduce spending on a patient population to favorably position themselves with payers or increase their margins from capitated contracts. They have provided comparative information about practice styles to educate their physician members about more efficient methods of care or patterns of service use. Information about a physician's practice style relative to his or her peers has also been used to distribute group income or to reward more efficient providers. A provider group that can demonstrate its efficiency relative to other groups in an area may have an edge in negotiating favorable terms and fees with payers. They may also profit more from capitated contracts than less efficient groups.

Comparing Physician Practice Patterns

While the methods to identify efficient providers vary and definitions of key concepts differ, profiling for the purposes of providing feedback or distributing financial rewards requires aggregating billing information by patient and then associating patients with the physicians who care for them. The data for each physician are compiled so that the resource use profile of an individual physician's patients can be compared with a standard. The standard may be the average resource use of all physicians in a group or a benchmark that accounts for differences in quality and patient needs.

The details of how physician profiles are developed can greatly affect which physicians are identified as having efficient or inefficient practice patterns. Decisions about which services should be included in the profiling report make a difference. For example, should only physician visits be counted or should all services be documented, including hospitalizations and pharmaceuticals? The assignment of the physician accountable for each patient is also important because it may hold a doctor responsible for the services provided by another. Accounting for patient mix is also critical. Clearly, some patients need more medical services than others and some physicians treat more complex patients. So in making any resource use comparisons across physicians, it is important to account for variations in patient needs. Without adequate adjustments for the

health status of a physician's patients, physicians with a higher number of complex patients would appear to be less efficient than others and physicians with fewer complex patients would seem more efficient.

The results of profiling techniques may be used in several ways by health plans or provider groups. Health plans may provide the comparative information to physicians to illustrate differences in practice styles to encourage the adoption of more efficient options or the best practice. Physicians may find this type of private feedback to be the most acceptable use of profiling. Profiling techniques that involve the public release of results or that incorporate financial incentives may be quite a different matter. Plans may publicly release profiling data to influence patients or other providers to choose the most efficient ones. The comparisons may be more directly linked to pay through health plan preferred provider tiers, with lower co-payments or more favorable fees to the more efficient, or even used by provider groups in the calculation of physician salaries or bonuses.

Using Physician Profiling in Medicare

The Government Accountability Office (GAO) recently reported on the feasibility of linking physician compensation to efficiency of caring for Medicare beneficiaries.² Inefficient physicians, or outliers, were defined as physicians who had extremely high resource use patterns relative to their peers. The Medicare Payment Advisory Commission (MedPAC) released a report on alternative mechanisms for controlling Medicare physician expenditures, which included profiling.³ MedPAC aggregated claims data based on episodes of care and then compared physicians on service use patterns across patients with the same condition. Both congressional support agencies indicated that the comparative physician information developed through profiling techniques holds promise in slowing spending growth.

The Centers for Medicare & Medicaid Services (CMS) has indicated that it is pursuing physician profiling as a strategy for the Medicare program. In recent testimony before Congress, Acting Deputy Administrator Herb Kuhn said, "We are investigating ways to measure individual physician resource use that links quality in the provision of care to Medicare beneficiaries and encourages physicians to focus on efficiency. A goal of resource use measurement is to provide information that is meaningful, actionable, and fair to physicians in order to reduce inefficient practice patterns."⁴ In comments on the GAO report, CMS Acting Administrator Leslie Norwalk wrote, "...given the role of physicians in driving total Medicare spending, there is opportunity to increase the efficiency of the Medicare program by measuring and reporting on physician resource use."⁵

How profiling techniques would be applied in the Medicare context needs further discussion. Without legislative changes in the fee-for-service

Medicare program, Medicare would only be able to use profiling data to show physicians how the services provided to their patients differ from the services used by patients of other physicians. But, as GAO points out, health plans usually link profiling results to some type of financial incentives. Changing Medicare so that it could incorporate financial incentives tied to the efficiency of care would be a fundamental shift in how the program interacts with providers.

Profiling to Achieve Savings

There is little evidence on the extent of savings (or reductions in cost growth) that can be attributed to the adoption of profiling efforts. This may be due to the complex interplay of factors that affect health care costs and the growth in service use and the shift to more intensive practice styles. Attributing differences in spending trends to any particular intervention can be quite difficult. Market factors, such as the availability of providers and their market power, would affect the ability of payers to influence physician practice styles. Research findings on new treatments or new applications of existing treatments may supplant profiling results to change physician practice. Other economic incentives, such as the ability to profit from ancillary services or inadequate payment for providing other services, may exert more influence over provider decisions than any incentives that could be tied to profiling.

At this Forum session, Bruce Steinwald from GAO will review his organization's recent report and take a look at profiling with respect to Medicare's fiscal problems. Dr. Eric Nielsen, chief medical officer of the Greater Rochester Independent Practice Association, will discuss his provider group's experience with profiling as a means to modify physician behavior to improve quality of care and reduce costs over time. Dr. Dale Magee, president of the Massachusetts Medical Society, will present information about the use of physician profiling in Massachusetts' state employee health plan negotiations and concerns among physicians about this use of profiling.

KEY QUESTIONS

- What factors need to be considered in comparing resource use across physicians? Is it possible to adequately account for differences in patient need and quality of services received that may explain differences in physician resource use? Should local practice styles be accommodated in profiling methods?
- Will private feedback of profiling results cause changes in physician practice styles? What types of financial incentives promote efficient practice styles? Should the Medicare program incorporate financial incentives to promote efficient practice styles? How?

Key Questions / continued ►

Key Questions / continued

- Will physician profiling, with or without financial incentives, be sufficient to slow Medicare spending? What unintended consequences could result from using profiling in the Medicare program?

ENDNOTES

1. Congressional Budget Office, *Factors Underlying the Growth in Medicare's Spending for Physicians' Services*, June 2007; available at www.cbo.gov/ftpdocs/81xx/doc8193/06-06-MedicareSpending.pdf.
2. Government Accountability Office (GAO), *Medicare: Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency*, GAO-07-307, April 2007; available at www.gao.gov/new.items/d07307.pdf.
3. Medicare Payment Advisory Commission, *Report to the Congress: Assessing Alternatives to the Sustainable Growth Rate System*, March 2007; available at www.medpac.gov/documents/Mar07_SGR_mandated_report.pdf.
4. Herb Kuhn, Centers for Medicare & Medicaid Services, statement before the Committee on Ways and Means, Subcommittee on Health, U.S. House of Representatives, May 10, 2007, p. 4; available at <http://waysandmeans.house.gov/Media/pdf/110/5-10-07/KUHNTestimony.pdf>.
5. GAO, *Medicare: Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency*, p. 44.



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