Cost Profiling of Physicians Often Inaccurate

BY MARY ANN MOON

Current methods for profiling physicians as to whether they provide low- or high-cost care are often inaccurate and produce misleading results, according to a report in the New England Journal of Medicine.

Health plans use cost profiling to limit how many physicians get in-network contracts and to allot bonuses to the physicians whose "resource use" is lower than average. In each case, there must be a method for determining physicians' costs, yet the accuracy of these methods has never been proved, according to John L. Adams, Ph.D., of Rand Corp., Santa Monica, Calif., and his associates.

"To our knowledge, the reliability of physician cost profiling has not been previously addressed," they noted.

Dr. Adams and his colleagues assessed the reliability of current methods of cost profiling using claims data from four Massachusetts insurance companies concerning 1.1 million adult patients treated during 2004-2005. The 12,789 physicians included in the study were predominantly men who were board certified, had been trained in the United States, and had been in practice for more than 10 years.

The physicians worked in 28 specialties, including endocrinology, cardiology, gastroenterology, and obstetrics and gynecology. Family physicians, general physicians, and internal medicine physicians comprised approximately one-third of the sample.

The investigators estimated the reliability of cost profiles on a scale of 0-1, with 0 representing completely unreliable profiles and 1 representing completely reliable profiles. They then estimated the proportion of physicians in each specialty whose cost performance would be calculated inaccurately.

Overall, 41% of physicians across all specialties had cost profile scores of 0.70 or greater, a commonly used threshold of acceptable accuracy. Only 22% of endocrinologists, 47% of internists, 30% of cardiologists, 41% of family or general physicians, 57% of ob.gyns., and 59% of gastroenterologists received scores of 0.70.

Overall, only 9% of physicians in the study had scores of 0.90 or greater, indicating optimal accuracy.

The proportion of physicians who were classified as "lower cost" but who were not lower cost ranged from 29% to 67%, depending on the specialty. Fully 50% of endocrinologists, 50% of internists, 40% of cardiologists, 39% of family or general physicians, 36% of ob.gyns., and 32% of gastroenterologists were misclassified as "lower-cost" providers when they were not.

In addition, 19% of endocrinologists, 22% of internists, 14% of cardiologists, 16% of family or general physicians, 10% of ob.gyns., and 11% of gastroenterologists were misclassified as "higher cost" when they were not in fact higher cost.

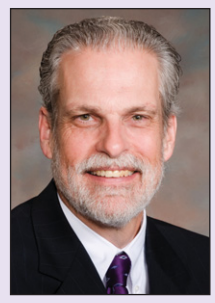
These findings indicate that standard methods of cost profiling are highly unreliable, and that many individuals and groups are basing important decisions on inaccuracies. "Consumers, physicians, and purchasers are all at risk of being misled by the results produced by these tools," the investigators concluded (N. Engl. J. Med. 2010;362:1014-21).

The findings also suggests that cost profiles based on these methods will not reduce health care spending. "There are serious threats to insurance plans' abilities to achieve cost-control objectives and to patients' expectations of receiving lower-cost care when they change physicians for that purpose," they added.

This study received support from the Department of Labor, the National Institutes of Health, and the Robert Wood Johnson Foundation. The investigators' conflicts of interest included support from the Physicians Advocacy Institute, Commonwealth Fund, and Ingenix Inc. ■

MY TAKE

Abandon Seriously Flawed Programs



The RAND Corporation study verifies the American Medical Association's longstanding contention that there are serious flaws in health insurer programs that attempt to rate physicians based on cost of care.

The RAND study shows that physician ratings conducted by insurers can be wrong up to two-thirds of the time for some groups of physicians. Inaccurate information can erode patient confidence and trust in caring physicians, and disrupt patients' longstanding relationships with physicians who have cared for them for years.

Patients should always be able to trust that the information they receive on physicians is valid and reliable, especially when the data are used by insurers to influence or restrict patients' choice of physicians.

Given the potential for irreparable damage to the patient-physician relationship, the AMA calls on the health insurance industry to abandon flawed physician evaluation and ranking programs, and join with the AMA to create constructive programs that produce meaningful data for increasing the quality and efficiency of health care.

J. JAMES ROHACK, M.D., *is president of the American Medical Association. He reported no conflicts of interest.*

ACGME Is Urged to Restrict Residents' Work Hours

BY ALICIA AULT

A new advocacy coalition is putting pressure on the Accreditation Council for Graduate Medical Education to speed up its process of developing new recommendations on work hour restrictions for residents—and to closely follow the Institute of Medicine's recommendations by further reducing hours.

The coalition, led by Public Citizen, sent a letter to Dr. Thomas J. Nasca, ACGME's executive director, urging the accrediting body to adopt rules that aim to reduce sleep deprivation and to better protect patients, Dr. Sidney Wolfe, director of Public Citizen's Health Research Group, said in a briefing with reporters.

"The available evidence suggests that the public is deeply concerned about the current work hours of medical residents," stated the letter, which is posted at www.wakeupdoctor.org.

At the briefing, Dr. John Ingell, a fourth-year surgical resident at the University of New Mexico, Albuquerque, said that he became less compassionate when severely fatigued. Concentration also suffered, said Dr. Ingell, who is on the board of the Service Employees International Union's medical resident section.

Dan Henderson, a third-year medical student at the University of Connecticut, Farmington, said that at the time, he was proud to work 12 hours or more a day or a 30-hour continuous shift on his surgical rotation. Now, he feels "ashamed," because he has realized that such efforts did not improve his education and had a negative effect on his feelings for patients.

He said he supported the limit on work hours recommended by the IOM in 2008. The IOM urged a reduction from 30-hour shifts to shifts no longer than 16 hours. "I really think medicine needs a wake- up call and needs to move into the 21st century," said Mr. Henderson.

The ACGME had planned on reviewing the work hours 5 years after they were first reduced, which happened to coincide with the IOM's report, Dr. Nasca said in an interview. The 16-member Duty Hours Task Force has been meeting since last July. New draft standards are likely to be issued by late April, and then available for public comment for 45 days, he said.

At the briefing, Dr. Charles A. Czeisler, professor of sleep medicine at Harvard Medical School, Boston, said that the current ACGME standards are widely flouted. Confidential surveys of residents have shown "widespread falsification" by trainees on their actual work hours, he noted.

Dr. Nasca responded that the ACGME is an educational accreditor, "not an employment regulator. … Our goal is to ensure substantial compliance with the regulations."

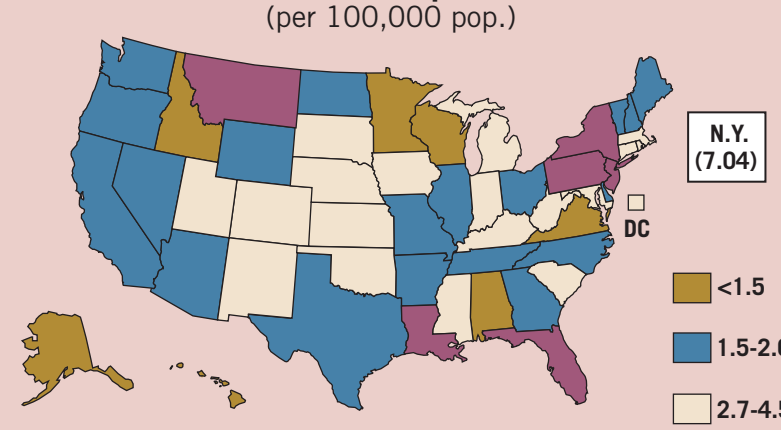
There is a tension between the educational mission, safety, and other factors, acknowledged Dr. Nasca, adding that this is why the Duty Hours Task Force had gathered evidence and opinions from more than 140 organizations.

"There's a constant balance we have to take between setting realistic expectations for how residents are scheduled for duty and the expectations that programs comply with those, coupled with the desire to inculcate in physicians a sense of personal responsibility for the safety and care of each individual patient," said Dr. Nasca.

The risk of fatigue also has to be balanced against the risk of increased errors when patients are handed off to an increasing number of caregivers, he said. ■

DATA WATCH

New York Led U.S. in Paid Malpractice Claims for 2008
(per 100,000 pop.)



Note: Based on a National Practitioner Data Bank analysis of claims involving allopathic and osteopathic physicians, interns, and residents.
Sources: Kaiser Family Foundation, Census Bureau

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