Accuracy of Cost-Profiling Methods Under Fire

BY MARY ANN MOON

Current methods for profiling individual physicians as to whether they provide low-cost or high-cost care are often inaccurate and produce misleading results, according to data from a recent Rand Corp. study.

Health plans use cost profiling to limit how many physicians get in-network contracts and to allot bonuses to those 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. and his associates.

The investigators 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. In all, 12,789 physicians were included in the study.

They 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.

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.

Only 41% of physicians across all specialties had cost-profile scores of 0.70 or greater, a commonly used threshold of acceptable accuracy (N. Engl. J. Med. 2010;362:1014-21). 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 in fact lower cost ranged from 29% to 67%, depending on the specialty. ■

Disclosures: *This study was supported by the Department of Labor, the National Institutes of Health, and the Robert Wood Johnson Foundation. The investigators' conflicts of interest include support from the Integrated Healthcare Association, American Medical Association, American Board of Medical Specialties, Arkansas Medical Society, American Board of Internal Medicine Foundation, Massachusetts Medical Society, Physicians Advocacy Institute, Commonwealth Fund, and Ingenix Inc.*

MY TAKE

Abandon Flawed Evaluation Programs

The Rand 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 study shows that such ratings 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 us 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.*

More 'Comparative Effectiveness' Studies Needed to Improve Quality of Care

BY MARY ANN MOON

A review of the recent literature confirms that "comparative effectiveness" research—studies designed to help physicians use existing treatments more effectively—is severely lacking.

Fewer than a third of the studies published in the six top journals qualified as comparative effectiveness (CE) research. This finding "supports concerns that only limited clinical research is currently devoted to helping physicians" improve the use of existing therapies and determine which interventions and strategies are the most effective and safe, and the least costly, said Dr. Michael Hochman and Dr. Danny McCormick of Cambridge (Mass.) Health Alliance and Harvard Medical School, Boston.

Congress recently passed legislation to provide more than $1 billion to support CE studies, and President Obama's budget for 2011 recommends further funding of CE research. Noting that few data are available on the current status of CE research, the investigators reviewed all clinical medication-assessment studies published between June 2008 and October 2009 in the New England Journal of Medicine, Lancet, JAMA, Annals of Internal Medicine, British Medical Journal, and Archives of Internal Medicine. These publications "are the most widely read, quoted, and covered by the media, and thus are disproportionately likely to influence clinicians," the investigators said (JAMA 2010;303:951-8).

Of the 328 randomized trials, observational studies, or meta-analyses, only 104 (32%) were CE studies. Only 11% of the CE studies compared medications with nonpharmacologic treatments, confirming a relative lack of such research. Such studies are important because they help clinicians "make fundamental therapeutic decisions," the investigators said.

Nearly 90% of the CE studies relied on noncommercial funding, primarily from government sources, a finding that highlights how essential such funding is. "Commercial entities presumably devote much of their research to the development of novel therapies and to funding inactive-comparator studies aimed at expanding indications for their products," they noted.

More than half of the randomized trials in this analysis used an "inactive comparator" such as placebo, rather than comparing a medication against existing treatments. Such trials were disproportionately funded by commercial sources and were disproportionately likely to show that a medication produced positive results. In addition, 24% of the randomized trials that did use an active comparator sought to demonstrate only the noninferiority of a medication to that comparator; there was no effort to clarify the optimal therapy, only to test equivalency. Such trials were exclusively funded by commercial sources.

Only 19% of the CE studies focused on patient safety, which implies that safety concerns are not adequately emphasized in medication studies.

Only 2% of the CE studies and 1% of all studies in the analysis included formal cost-effectiveness analyses, which are critical to promoting efficient health care.

Overall, the findings "underscore the importance of the recent legislation passed in the United States to expand public funding for CE studies. In particular, our findings suggest government and noncommercial support should be increased for studies involving nonpharmacologic therapies, for studies comparing different therapeutic strategies, and for studies focusing on the comparative safety and cost of different therapies," Dr. Hochman and Dr. McCormick said. ■

Disclosures: *The investigators reported no financial conflicts of interest.*

Feds to Test Two EHR Certification Programs

BY MARY ELLEN SCHNEIDER

The federal government has put forward its plan to test and certify electronic health records in preparation for the Medicare and Medicaid incentive program that will reward physicians for using health information technology.

The proposed rule establishes a temporary certification program in which Dr. David Blumenthal, National Coordinator for Health Information Technology, will designate certain organizations to test and certify complete electronic health records (EHRs) and related modules. Dr. Blumenthal's office would take on many of the functions (such as accreditation) that will later be performed by private groups. The idea behind the temporary program is to ensure that certified EHR products are available before the first incentives for use of certified systems begin in 2011.

The rule also proposes the creation of a permanent, more sophisticated certification program that would eventually replace the temporary one. It would divide the responsibility for testing and certification among different organizations, and would set forth the requirement that certification bodies perform surveillance of certified EHR products. Certification bodies also may be able to assess additional health information technology products beyond EHRs and their modules. Both certification programs would be voluntary.

Dr. Blumenthal called publication of the proposed rule an "important first step" to bringing structure to the evaluation of EHRs and EHR modules. "The programs will help support end users of certified products, and ultimately serve the interests of each patient by ensuring that their information is securely managed and available," he said in a statement.

Earlier, the government issued a proposed rule outlining criteria for meaningful use of EHRs and an interim final rule that included an initial set of standards and specifications for product certification. ■