Cost-Profiling Methods Often Found Inaccurate

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 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 proven, according to John L. Adams, Ph.D., of Rand Corp., Santa Monica, Calif., and his associates.

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. A total of 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, including obstetrics and gynecology, cardiology, endocrinology, and gastroenterology. Family physicians, general physicians, and internists comprised approximately one-third of the sample.

Only 57% of ob.gyns. and 41% of physicians overall had cost profile scores of 0.70 or greater, a commonly used threshold of acceptable accuracy.

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, only 41% of physicians across all specialties had cost profile scores of 0.70 or greater, a commonly used threshold of acceptable accuracy. Only 47% of internists, 30% of cardiologists, 41% of family or general physicians, 57% of ob.gyns., 59% of gastroenterologists, and 22% of endocrinologists 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 in fact lower cost ranged from 29% to 67%, depending on the specialty. Fully 50% of internists, 40% of cardiologists, 39% of family or general physicians, 36% of ob.gyns., 32% of gastroenterologists, and 50% of endocrinologists were misclassified as "lower-cost" providers when they were not.

In addition, 22% of internists were misclassified as "higher cost" when they were not in fact higher cost.

This same misclassification occurred as well for 14% of cardiologists, 16% of family or general physicians, 10% of ob.gyns., 11% of gastroenterologists, and 19% of endocrinologists.

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 study findings also suggest that using cost profiles that are based on these unreliable 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. ■

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HHS Awards $162 Million to States for Health IT Exchange

BY MARY ELLEN SCHNEIDER

The federal government has awarded $162 million in grants to states to aid in the secure exchange of health information across different proprietary systems.

The grants, which were announced on March 15, will go to 16 states and qualified state-designated entities. The money was set aside for states under the American Recovery and Reinvestment Act of 2009. This is the final round of grants, and follows the release of $385 million to 40 states and qualified state-designed entities in February.

"What these awards will do is strengthen our health care system and speed our economic recovery," Kathleen Sebelius, Health and Human Services Secretary, said during a press conference to announce the grants. "They help to unleash the power of health information technology to cut costs, eliminate paperwork, and best of all help doctors deliver higher quality, coordinated care."

Despite the benefits of adopting electronic health records (EHRs), only about 20% of physicians and 10% of hospitals have implemented even a basic EHR system, Ms. Sebelius said.

The goal in awarding these grants is that the states will be able to develop policies and frameworks based on nationally approved technical standards, which will allow physicians and hospitals to securely share information regardless of what type of EHR system they have implemented.

States will need to begin by bringing all the parties to the table—from physicians and hospitals to health insurers and lawyers, said Dr. David Blumenthal, the national coordinator for health information technology. These groups will need to agree on the strategic and operational plans for creating health-information exchange in each state, he said.

Health IT officials at the federal level will be working closely with the states on their plans for exchanging health data. But the states are in the best position to identify and credential physicians and hospitals that should be receiving and sending private and secure health information transmissions, Dr. Blumenthal said.

The states are currently at different points in their implementation timeline based on their past work on health information exchange, Dr. Blumenthal added. But he said he expects that many states will have the technology and governance structures in place by 2013 to allow physicians and hospitals to meet the information exchange requirements established under the federal incentive program for EHR implementation. That incentive program, created under the Recovery Act, calls for physicians and hospitals to demonstrate the ability to exchange information by 2011, but more robust exchange requirements do not phase in until 2013. ■