I. Introduction

Each year, America’s rapidly rising health care costs become the focus of congressional attention as physicians seek relief from Medicare reimbursement cuts. Such cuts are typically mandated by the Sustainable Growth Rate (SGR) formula, intended to hold physician expenditures to a target amount tied to Gross Domestic Product (GDP).\(^1\) Physician expenditures continue to grow excessively relative to GDP\(^2\) and policymakers are struggling to find a way to contain these costs.

One tool that might be employed is “physician profiling,” that is, comparing physicians to each other and using the results in different incentive programs. Health plans and other payors are using episode-grouper software to measure physicians’ resource use as one way to profile physicians.\(^3\) Typically, the software groups file claims for services related to a patient’s diagnosis, including services provided by the physician, tests and diagnostic work, services provided by specialists, and inpatient and outpatient procedures.\(^4\) The software’s programming logic then attributes the resources to a single physician, defines the beginning and end of the episode, and separates out services related to other conditions that the patient may have.\(^5\) The resulting product is a profile that compares the efficiency (and sometimes the quality) of care delivered by different physicians to patients with similar conditions.\(^6\)

Physicians have discussed possible uses for this information. The least aggressive use of this information is for confidential reporting. Some hope that if physicians become aware of how they compare to others, they will modify their practice pattern.\(^7\) More intrusive uses include public disclosure as a basis for pay-for-performance bonuses or penalties, to place low-resource-use physicians on preferred tiers, and exclude high-resource-use physicians from a network altogether.

Physician profiling may offer promise as a way to rid the health care system of inefficiency—believed by many experts to constitute up to 30% of expenditures.\(^8\) Adoption of these techniques by Medicare, however, will likely provoke conflicts and difficult choices.

II. Background

The rationale for pursuing accountability-based approaches to paying physicians is well stated by the Institute of Medicine (IOM) in the introduction to its report on pay-for-performance, *Rewarding Provider Performance: Realigning Incentives in Medicare*:

> The current Medicare fee-for-service payment system is unlikely to promote quality improvement because it tends to reward excessive use of services; high-cost, complex procedures; and lower-quality care. Through bundled and prospective payment arrangements for institutions, Medicare has attempted to create incentives for efficiencies, but significant price and payment distortions persist.\(^9\)

The National Quality Forum (NQF) has summarized what is at stake:

> Waste in the healthcare system has a negative impact on individual patients and populations. All encounters with the health system expose patients to some degree of risk, and the provision of unnecessary services to patients exposes them to more potential harm than good, not to mention inconvenience and often monetary costs. The provision of unnecessary services could account for as much as 30% of all health care expenditures, and this waste is felt not only by the health care system itself but, ultimately, by individual patients and populations as well.
suggested that further steps should be taken, following the trail blazed by private insurers.

III. Variation in Physicians’ Resource Use

A number of studies that use physician practices as the unit of analysis find wide variation in resource use intensity for similar patients, and suggest that the Medicare program would save a substantial amount of money if more doctors adopted the practice styles of those at the high end of the efficiency distribution.

Jonathan Weiner examined three sets of physician claim data to derive risk-adjusted efficiency comparisons, finding that:

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\text{The difference in the case-adjusted efficiency between the } 30\% \text{ of physicians that represent the most efficient cohort, and the } 30\% \text{ that are the least efficient, was consistently at least } 0.8 \text{ vs. } 1.2 \text{ of average (average is set at 1.0) for all three databases. This means that the patients of the most 'efficient' group of providers (after case-mix was taken into account) used on average } 20\% \text{ less services than expected while the patients of the least efficient cohort of physicians used services that were } 20\% \text{ more than expected.}
\]

MedPAC explored variations in physician resource use utilizing episode-grouper software supplied by commercial vendors. This software allows comparisons of the average resource use of physicians for similar episodes involving similar patients. MedPAC studied variation among several physician specialties and found that for ophthalmologists, dermatologists, internists, cardiologists and allergists, resource use per episode varied twofold or more between physicians in the highest and lowest deciles of intensity.

The Government Accountability Office (GAO) identified “outlier” physicians as generalists who saw a disproportionate share of beneficiaries who accrued medical bills that were unusually high, considering their health status. After taking health status and location into account, GAO found that:

Medicare patients who saw an outlier generalist—compared with those who saw other generalists—were 15 percent more likely to
have been hospitalized, 57 percent more likely to have been hospitalized multiple times, and 51 percent more likely to have used home health services. By contrast, they were 10 percent less likely to have been admitted to a skilled nursing facility. We concluded that outlier generalists were likely to practice medicine inefficiently.24

IV. Private Plan Activity
A recent report from the Center for Studying Health System Change (HSC) described how private insurers have responded to variations in physician efficiency by identifying “high-performance networks that encourage enrollees to choose network physicians who score well on measures of efficiency and quality.”25 These insurers have used the episode-grouper software to determine whether physicians complied with recommended processes during a treatment episode, as well as the total cost of an episode.26

HSC reported that:

High-performance networks typically are not distinct products, but rather an option for use across different product platforms, most commonly preferred provider organizations (PPOs).

The exact specifications of high-performance networks differ across plans. The most common model uses tiered-provider levels, with corresponding enrollee cost-sharing differentials. The first tier consists of the high-performing providers; the second tier consists of the remainder of in-network providers; and the third tier consists of out-of-network providers. Employers often do not differentiate cost sharing between the first and second tiers, offering these networks only as a source of information to their employees about which providers have better performance.27

HSC noted, however, that at least one health plan cut the lowest performing “outlier” physicians from its network altogether, and that another would consider taking this step as well for physicians who fail to change their ways even after receiving specific information on how to improve.28 Conversely, one prominent insurer, United Healthcare, is paying additional reimbursements to physicians in its top tier.

Based on the private plan experiences, HSC identified several barriers to the operation of tiered networks as follows. First, a perceived lack of legitimacy of efficiency measures is apparent when different data sets, different ranking systems, or different cutoff points result in the same physician being designated as superior by one insurer but not by another, or being designated superior one year but not the next. Variation in scores can be explained by different prices negotiated with different purchasers, yet physician perception of inequities has resulted in pushback.29 Employers’ reluctance to take the heat for the stern measures needed to enforce a tiered network (i.e., telling enrollees they must pay more to see particular physicians, especially when doing so may disadvantage enrollees in particular locations).30 There was a lack of evidence that tiered networks lower health care costs or inducing widespread change in physician behavior.31

While the rollout of individual measures has been rocky, resistance could be expected in an early-adoption phase during which there is a lack of standard measures or benchmarks, disparate insurers analyzing different data, and some clumsiness on the part of insurers in introducing the programs to doctors. Presumably, some of these deficiencies can be overcome by the time that Medicare adopts efficiency measures. On the other hand, as will be discussed below, several real obstacles will provide challenges.

V. Policy Options for Medicare
Implementation of any policies based on physician profiling is complicated first by questions about whether episode-grouper techniques are sufficiently refined to effectively measure physician resource use.32 Certainly, none have undergone the sort of scrutiny that has been afforded to quality and patient experience measures promulgated by quality promotion organizations such as the NQF or National Council for Quality Assurance. Issues related to accuracy, validity, and risk-adjustment pose unanswered questions.

A. Accuracy issues.
Accuracy issues would include the inability to attribute patients to the appropriate doctor when multiple doctors see the patient, incomplete clinical information in claims data, or an insufficient number of episodes involving a specific condition from which to calculate reliable measures.33

B. Validity issues.
Validity issues relate to what constitutes the “correct” intensity of resource use for a given episode. In the absence of evidence as to best practices, benchmarks may be based instead on convenience, such as averages or arbitrary percentiles. Validity, or the perception of validity, can also be hindered by a lack of stakeholder consensus and the opacity of proprietary software programs.
C. Risk adjustment issues.

Measures that do not properly account for the severity of a patient’s illness would not only be inaccurate but could also discourage physicians from treating the sickest patients. A separate but similar issue arises from patient behavior that doctors cannot control, such as patients’ failure to adhere to treatment plans or healthy lifestyles, inability to afford prescription drugs, or demands for specific expensive services.34

Policymakers hoping to spur greater efficiency among physicians delivering care to Medicare patients can choose from a menu of policy options. The options span a continuum that ranges from voluntary and collaborative quality improvement efforts to increasingly rigorous approaches.

VI. Feedback

The mildest policy option is for the Centers for Medicare and Medicaid Services (CMS) to provide confidential feedback to physicians about how their resource use compares with that of peers. The rationale for this option is physician professionalism. As MedPAC observed, “[m]any physicians are highly motivated individuals who have continually strived for high grades and peer approval. If identified as having an unusually resource-intensive style of practice, some physicians may respond by reducing the intensity of their practice.”35 In fact, CMS is already preparing a demonstration project that will use the episode-grouper software to provide feedback to physicians on selected illnesses.36

MedPAC also observed:

Evidence on measuring the effectiveness of resource use in containing private sector costs is mixed and varies depending on how the results are used. Providing feedback on use patterns to physicians alone has been shown to have a statistically significant, but small, downward effect on resource use, but, when paired with additional incentives, the effect on physician behavior can be considerably larger.37

MedPAC may be overly optimistic in assuming that providing feedback on resource use with an appeal to doctors’ professionalism would have the positive effect that it has in the clinical quality context. First, physicians may disregard feedback viewed as lacking validity and reliability. Second, the appeal of feedback to a doctor’s professionalism would have to overcome a very compelling countervailing force: the fee-for-service system’s incentive to provide more care. The “target income hypothesis” holds that physicians maintain a volume and intensity of practice sufficient to achieve their preferred balance of profit and leisure.38

It may be that the “inefficient” or “outlier” physician is busy, a bit disorganized, and simply has a cavalier attitude toward the use of resources; this physician might be interested in learning about her peers’ best practices. On the other hand, she may have a relatively small patient load and “induce demand” for frequent evaluation and management visits or referrals to her own ancillary services, such as imaging, to maintain her standard of living. To be efficient, this physician might have to advertise or take emergency room duty to build a larger patient base, or relocate from an area saturated by a high concentration of physicians to a rural community. The physician may be forced to forgo income necessary to amortize an investment in equipment.

VII. Public Reporting

Further along the incentive continuum is the concept of public reporting of physician efficiency. Efficiency reporting could come to pass by two possible avenues. First, Medicare could take the lead in tabulating and releasing efficiency measures. This approach is embodied in S. 1544, legislation co-sponsored by Senator Judd Gregg (R-NH) and former Senator Hillary Clinton (D-NY) in the 110th Congress.39 This bill would authorize the creation of Medicare Quality Reporting Organizations which, under contracts with the Department of Health and Human Services (HHS), would publicly release quality and efficiency reports based on Medicare data.40

Second, other entities, such as states, public interest groups, or commercial vendors could use Medicare claims data to tabulate and disseminate the information. Consumer advocates had hoped that the claims data needed to measure individual physicians’ resource use would be available to the public through the Freedom of Information Act, but a recent court decision has cast doubt on that possibility.41 It is not clear whether public reporting could begin to move forward without any further legislative or executive action.

“Transparency” has been the focus of several major health care initiatives in recent years, including those of the recent Bush Administration. Measuring and reporting price information was one of the four cornerstones of that administration’s Value-Driven Health Care initiative. HHS has already begun posting the prices of various discrete procedures, but has acknowledged that “measuring the overall cost of services for common episodes of care and the treatment of common chronic diseases” is a necessary second step in achieving cost transparency.42

A prominent private-sector effort is the Consumer-Purchaser Disclosure Project, which advocates public reporting of efficiency measures as a “path to significant savings in health care.”43 Citing the Weiner research referenced above and other similar research, it contends that “Medicare and other purchasers could save from 2% to 4% of total costs if only one out of ten beneficiaries were to move from less efficient to more efficient physicians.”44 The group has also called for HHS to release Medicare physician billing data to private insurers to enable better comparisons of provider efficiency.

Reporting of efficiency measures may be a double-edged sword—skeptical consumers, left cynical in the wake of perceived managed-care excesses, could view an “efficient” physician as one who skimps on care, and see physicians with more intense resource use as those who are willing to go the extra mile for their patients. For reporting of efficiency measures to have the intended effect, the public must feel assured that “inefficiency” means additional care that provides no marginal benefit.

Progress toward public reporting of efficiency measures is hindered by the concerns over the accuracy, validity, and risk adjustment issues outlined above. These concerns are magnified in the public reporting context because, with reputations and patient relationships at stake, physicians have not hesitated to litigate disputes over these issues. At present, doctors in Connecticut are in court challenging two insurers’ designations of superior practitioners as “a fraud upon the public and a libel against the plaintiff physicians” who were not so designated.45 Doctors in New York State
persuaded the State Attorney General to threaten lawsuits against three insurers planning similar programs, although that dispute has been settled as described below.

Judicial precedents relating to bond-rating agencies suggest that public reporting of physician efficiency ratings would be protected by the First Amendment, even if a court agreed that the ratings were useless to consumers. However, threats of litigation could discourage private entities from taking on this already intimidating task. It is clear that all stakeholders would be better off if a consensus could be reached in advance regarding ways in which to develop resource measures that are accurate, scientifically valid, and do not create perverse incentives for doctors to avoid the sickest patients.

Efforts toward such consensus measures are under way. In early 2007, the Integrated Healthcare Association, a California consortium that pioneered pay-for-performance programs, announced that it would develop efficiency measures to pair with its previously established quality criteria. Later the same year, the Robert Wood Johnson Foundation (RWJF) committed $16 million in grants to build a multiple-payer database to measure and report on physician performance. RWJF said that the project, to be overseen by the Quality Alliance Steering Committee, would:

[Work] in collaboration with the NQF endorsement process to identify measures of cost for 20 common conditions, resulting in a new set of measures that take into account appropriate use of resources and provide a broader picture of quality of care for these conditions.

Finally, negotiations spurred by the New York State dispute resulted in a multi-stakeholder agreement announced April 1, 2008, which will permit insurer-sponsored performance measurement programs to go forward, subject to review by a “nationally-recognized, independent health care quality standard-setting organization.” This “Patient Charter” contemplates scrutiny of heretofore “black box” ranking mechanisms and the eventual development of standards for resource use measurement that will have comparable legitimacy to currently accepted quality measures. However, at least one additional lawsuit has been filed by physicians subsequent to the agreement.

VIII. Tiered Networks

A further step toward applying pressure on physicians would be for Medicare to adopt the tiered network approach that some private plans have taken. In a January 1998 report, the National Academy of Social Insurance’s (NASI) Study Panel on Fee-For-Service (FFS) Medicare recommended that Medicare experiment with “best practices of private health plans,” including “PPOs, perhaps in which beneficiaries face lower Medicare premiums in exchange for a designated PPO physician.” The panel observed that, “[w]ith its large market share and significant data resources, FFS Medicare is in a relatively good position to identify and select preferred providers on the basis of quality or costs.”

Eighteen months later, NASI’s recommendation was echoed in a Clinton administration white paper on modernizing Medicare. That paper proposed creating a “Medicare Preferred Provider Option,” to be administered by “existing organizations with PPOs.” To create the PPO network, “practitioners’ and providers’ claims history and quality information would be assessed. Only those applicants with a demonstrated history of cost-effective medical practice patterns would be selected as preferred providers.” Under the Clinton proposal, beneficiaries choosing the PPO option would have lower cost-sharing responsibilities.

Both the NASI and Clinton administration papers cited the prevalence of preferred provider networks in the private sector, but neither addressed what long-term impact they intended a tiered network to have within FFS Medicare. One rationale for tiering doctors is that the variation in resource usage as a given and ask beneficiaries who choose to stay with less efficient doctors to internalize more of the costs that their choice imposes on the program as a whole. However, this approach assumes that patients have made a conscious choice to stick with an inefficient doctor. One question for Medicare in particular is whether there is sufficient access to doctors in the preferred tier. By definition, any preferred provider network limited to a given upper percentile of high-quality, efficient providers will have a limited capacity to absorb patients. Thus, some beneficiaries may be unable to access a top-tier physician because of patient load constraints, not because of choice. For these patients, charging a higher premium or higher co-insurance exacerbates the misfortune they are already experiencing as a result of their inability to access an above-average physician.

Another rationale for tiering would view the preferred provider network not as an end in itself, but as a means for influencing physician behavior. In other words, the ultimate expected outcome would not be a two-tier system, but rather a single tier operating at a higher level of performance, driven by the financial threat to practitioners who do not achieve an acceptable level of efficiency. If this could be accomplished, the inconveniences caused by tiering would be temporary, but would still cause burdens on beneficiaries during a turbulent implementation period.

IX. Payment Tied to Performance

The ideal endpoint of physician payment policy reforms would be an environment in which physicians who provide care of high clinical quality with appropriate resource use are paid more than physicians who provide less value per unit of work. The current system of administered pricing does not allow for differential fees for the most skilled or most efficient doctors. In a pay-for-performance regime, some entity would assess doctors’ value and adjust fees accordingly.

Two major pay-for-performance efforts currently underway that reward physicians for both efficiency improvements and clinical quality are the United Health Care (UHC) Practice Rewards program and Medicare’s Physician Group Practice (PGP) Demonstration.

The UHC program is based on “episodic efficiency,” with rewards in the form of higher pay. UHC’s episode-grouper software sorts physicians along quality and resource use dimensions. It requires physicians first to qualify on the basis of clinical quality as indicated by claims for the provision of guideline-mandated care. After meeting that threshold, physicians are then ranked on resource use. Imagining a grid in which physicians are placed vertically from top to bottom on a quality axis and ranked from right to left on an efficiency axis, physicians lying in the upper right quadrant are eligible for enhanced fees during the year following their designation, receiving a five percent increase to their commercial fee schedule.
As the IOM noted that another option would be to “penalize providers who exhibit the worst performance or the least effort to improve.” This could involve withholding some fraction of reimbursements from physicians whose performance does not meet efficiency standards. As the IOM observed, “such a system could generate considerable resistance among providers [and] providers who were not confident of their ability to improve might refuse to participate.”

The Physician Group Practice Demonstration is based upon “longitudinal efficiency,” with rewards in the form of shared savings. For each physician group practice (PGP), Medicare savings from the demonstration are calculated by comparing actual spending each program year to the PGP’s own base-year per-capita expenditures, adjusted by a comparison group’s expenditure growth rate. A bonus pool equal to 80% of savings is created if a PGP achieves Medicare savings of more than two percent. The PGP is entitled to 70% of the pool automatically, but can receive the entire pool of money only if it meets quality targets as well. The PGP model does not “penalize” inefficient resource use, but the provider risks losing any funds invested in improving performance.

A payment methodology that is both “gated” and based on “longitudinal efficiency” might be the most rigorous possible application of efficiency measures to pay-for-performance programs. A “gated” approach making clinical quality a necessary but not sufficient requirement ensures that there can be no backsliding on quality or stunting on care to earn a bonus. Longitudinal measures of care can cut across settings, beyond individual episodes, and over the longer term to promote coordination among the different providers who serve a single patient. By aggregating patients, these measures can also more readily tie rewards to outcomes. This is important because a key efficiency goal is the avoidance of acute episodes through better chronic illness management – an accomplishment that episodic measures may not be able to discern. In addition, analysis solely of an episode’s efficiency sheds no light on the question of whether the care was appropriate. An episode of treatment, though “efficient” in the sense of costing relatively little, may have been unwarranted altogether. Finally, longitudinal measures permit shared savings corresponding to the doctor’s actual efficiency advantage, rather than an arbitrary reward amount. As Weiner noted, for the top 30% of efficient doctors this can amount to 20% less spending, far exceeding the five percent bonus paid by UHC.

However, unless Medicare providers can be organized into some sort of accountable care organizations similar to physician group practices – on either a mandatory or a voluntary basis – longitudinal measures will be difficult to incorporate into payment methodology. Given the fragmented nature of the practice of medicine, with many solo or small group-based practitioners, episode-based evaluation is more feasible in the existing environment.

X. Prospects

MedPAC staff researchers, recently returned from a series of site visits on the topic, reported to the Commission that health plans see physician resource use measurement as representing “the future” of health care. Certainly, the news that the Integrated Healthcare Association and the QASC are initiating multi-stakeholder efforts as well adds to a sense of inevitability about the concept. The question for policymakers is how to incorporate efficiency measures into Medicare payment policy. Given the unsustainable rate of growth projected for the program, doing nothing is not an option. Inefficient resource use is also an urgent concern for Medicare beneficiaries, who are responsible for Part B premiums and roughly twenty percent of their health care costs through co-insurance.

Medicare has four progressively rigorous policy options. The first option, feedback, will soon be implemented on a pilot basis; proposed legislation in the House would expand it to all doctors. The second option, public reporting, seems to be moving ahead through private efforts. QASC has indicated its intention to issue reports by 2010, although resource use reports could presumably be blocked if the development of efficiency measures fails to achieve consensus support.

Public policy could come into play on public reporting through several circumstances. First, HHS can block access to data by continuing to contest freedom of information requests that seek claims files identifying physicians, or expedite access by lifting its objections. Second, in the event of an impasse in the proceedings of voluntary quality measurement organizations, congressional or agency action could overrule objections and charter an alternative process for endorsing efficiency measurement algorithms. Under the National Technology Transfer and Advancement Act, government policy favors the use of standards set by voluntary consensus bodies such as NQF. But the Quality Advisory Board proposed in S.1544 provides an example of how NQF could be sidestepped if necessary. Finally, HHS could post efficiency measures on its website, as it has with hospital quality measures.

The third option, tiering Medicare physicians, poses more thorny problems. HSC found that most employers are unwilling to charge workers more to see an inefficient doctor; it would seem all the more difficult for elected officials to impose this discipline on constituents. This option is further complicated by the geographic realities of regional variation in intensity and scarcity of doctors in rural areas. With regard to the former, we know that inefficient physicians are concentrated in certain states. If, as IOM has recommended, physicians are held to nationwide standards, one could imagine a scenario in which the lion’s share of a region’s doctors are placed in a lower tier, making it difficult for patients to switch. Patients in those regions are already paying higher co-insurance because of the more intense practice styles of their doctors. As a result, they would be punished for their doctors’ inefficiency, at least in the short run. If there were no meaningful
opportunity for patients to switch doctors, the intended incentives might not work in the long run, either. Similarly, patients in rural areas might be served by only a few doctors. If all were placed in a lower tier, the patients could have no choice but to pay the higher rate.

Medicare could closely scrutinize “outlier” doctors identified through profiling and exclude from the program those who do not change their practice patterns even after receiving actionable feedback. This could be disruptive to beneficiaries’ established relationships with physicians. The effect on beneficiaries depends on how many physicians were excluded from the program – if relatively few were excluded, this could affect existing relationships less than a tiering strategy that placed many physicians on a tier requiring higher cost sharing. Care would need to be taken to ensure that doctors are labeled as “outliers” only because they are truly recalcitrant and not because they serve a particularly ill patient panel. One assumption underlying these physicians’ practice style is that they work largely in areas that have a high concentration of physicians.67 Care needs to be taken to verify this assumption to ensure that patients do not experience access problems as the result of physicians’ exclusion.

Ultimately, beneficiaries and taxpayers will benefit most from a system that most directly aligns payment with performance. Achieving this will not be easy. A payment structure that rewards episodic efficiency might miss the bigger picture. MedPAC found that when observed on a per-episode basis, physicians in a high-cost region could appear to be more efficient than those in a low-cost region.68

As noted earlier, efforts to assess the resource use of individual physicians face daunting obstacles in terms of accuracy, validity, and risk adjustment. If resource use evaluation indeed represents “the future” of physician payment policy, it will be necessary to design transparent measurement mechanisms that address all such concerns to the reasonable satisfaction of stakeholders. Doctors who have felt aggrieved by efficiency measures have thus far turned to the courts and state attorneys general to overturn private efforts – one imagines that if they felt federal measures were unfair, they would turn to Congress. Policymakers need to keep close watch on the ongoing private-sector efforts to ensure that a public-domain product that can be used by Medicare eventually emerges. If such efforts lag, the Federal Government may have to provide research funding and perhaps a back-up process for certifying efficiency measures so that physician consent to an ultimate NQF imprimatur is not unreasonably withheld.

Among major advantages of individual physician measures are that they would allow the Medicare program and others to learn from physicians who use fewer resources while maintaining a high level of quality. They permit a better understanding of the differences between inappropriate volume growth and appropriate growth (e.g., from technology changes that improve care for patients); they generate information that could be used to identify best practices for the treatment of specified patients and conditions; and they promote individual physician accountability without requiring any large-scale restructuring of the existing physician marketplace.69

Perhaps the most serious disadvantage is the difficulty that individual doctors and small-scale practices would face in re-engineering care processes. HSC researchers have described the daunting obstacles overcome by Virginia Mason Medical Center doctors in improving their efficiency when excluded from Aetna’s top tier.70 The HSC findings raise the question: How could smaller provider organizations in non-supportive cultures be expected to implement such sweeping changes if salaried doctors in a large integrated delivery system, supported by leadership trained in the Toyota Production System and working in a community with conservative medical care patterns, endured enormous sacrifices in time and money to achieve efficiencies?

XI. Individual Accountability Versus Shared Accountability

In its report on pay for performance, the IOM argued that a primary goal of new payment incentives should be “to stimulate collaboration and shared accountability among providers across care settings for better patient-centered health outcomes.”71 As noted earlier, physician profiling builds on the assumption that individual physicians should be accountable for resources used in treating their patients.

Physician profiling is an “individual accountability” approach to efficiency, one which respects the traditional autonomy of the physician. In placing the locus of accountability at the individual physician level, it shares the tack taken by the PQRI measures and by the “Medical Home” model that would give primary care physician practices a per-patient-per-month payment, in addition to fee-for-service reimbursements, to coordinate the care of chronically ill beneficiaries.72

In contrast, a “shared accountability” approach is inspired by the staff and group models of physician practices associated with health maintenance organizations (HMOs) – although not by the HMO
itself, as it maintains fee-for-service as its basis for payment. “Shared accountability” approaches would apply pressure on individual physicians to act as though they were part of an integrated delivery system. Several leading health policy experts would like to see physicians grouped into “accountable care organizations” or “virtual networks.” These approaches are based on the belief that integrated systems are more efficient and better able to coordinate care across settings. Under these proposals, physicians might be placed in pools based upon an “extended hospital medical staff” that reaps bonuses or incurs penalties based on longitudinal measures of quality (such as outcomes) or efficiency of care delivered to the entire population served. Other models, involving “bundled payments,” would induce physicians and hospitals to cooperate to improve their efficiency in treating acute episodes by paying (or reconciling payments) en bloc.

Because only a relatively small proportion of America’s physicians are organized into staff or large group practices, the individual accountability approach is viewed as better able to take the medical practice environment as it is in formulating policy, rather than trying to reorganize it. Thus, PQRI adapts Healthcare Effective Data and Information Set (HEDIS) measures designed for health plans for use at the individual physician level, and physician profiling could, in theory, devolve price competition from the plan level to the individual physician level.

If the preferred attributes of integrated delivery systems—quality measurement, incentive incentives, and care coordination—can be replicated through either individual accountability programs or shared accountability programs, why would the IOM and many other health policy experts recommend more complex and intrusive shared accountability regimes? Based on an extensive review of research on the subject, Laura Tollen argues that the cohesion, scale, and formal affiliations that characterize organized delivery systems are responsible for their quality and efficiency advantages. She further proposes that seven characteristics of such systems create the dynamics necessary to achieve these advantages: strong physician leadership, organizational culture, clear shared aims, a governance structure, accountability and transparency, selection and workforce planning, and patient-centered teams.

XII. Conclusion

It is immediately apparent that although individual physician approaches may be able to impose transparency and accountability and may pay for creation of patient-centered teams to address chronic illness, they fall short of creating the cohesive peer relationships that would be fostered by the organized, shared accountability model. Physician profiling does create some checks on peers—physicians deemed responsible for an episode have an incentive to refer to high-quality, efficient specialists. The lack of longitudinal incentives also could allow gaming through the initiation of more episodes.

In contrast, shared accountability proposals require organization and leadership, and, in the case of the accountable care organization, would be likely to spawn governing structures and workforce planning. Other benefits would include increased ability to tie pay to outcomes, increased incentives for providers to coordinate care, and the fact that physician profiling would be overseen by physician peers rather than by the government. Of course, structures created to encourage these benefits would also be potentially vulnerable to gaming.

It should be noted that both the individual and shared accountability approaches are intended to respect physician and patient autonomy by retaining, while restraining, fee-for-service payment. In this regard, the shared accountability proposals fall far short of capitated risk and managed care practices that have troubled physicians and patients alike. When satisfactory measures of individual physician efficiency are implemented, policymakers will have to determine whether Medicare, in making individual accountability rather than shared accountability the norm, would merely be recognizing as inevitable the fragmented nature of care delivery, or would reinforce it.

1. 42 U.S.C. § 1395w-4 (2008) establishing the SGR, which sets a target for physician expenditures, which is permitted to grow with national income and expansion of services to beneficiaries.
5. Id.
6. Id.
15. Medicare Payment Advisory Comm’n, Report to the Congress: Assessing Alternatives to the Sustainable Growth Rate System (March 2007) [hereinafter MEDPAC 2007].
16. Id. at 145. (This has also been referred to as an “outlier” approach, or a “practice pattern” or “clinical resource measurement” approach).
17. See Medicare Payment Advisory Comm’n, Report to the Congress: Medicare Payment Policy (March 2009).
18. Also worth noting is that some care cannot be attributed to any physician.
22 Id.
24 Id.
26 Id.
27 Id. at 1.
28 Id.
29 Id.
30 Supra note 25 at 1.
31 Id.
33 One issue receiving attention from researchers is the number of cases required to assign reliable rankings to physicians, which may exceed the number of episodes that most individual physicians have treated.
34 See, e.g., Howard B. Beckman, Thomas Mahoney & Robert A. Greene, Current Approaches to Improving the Value of Care: A Physician’s Perspective (2007).
35 MEDPAC 2007, supra note 15.
36 “CMS Launches Effort to Gauge Physician Resource Use to Control Costs,” Inside CMS, June 1, 2006.
37 MEDPAC 2005, supra note 4.
40 Id.
41 Id.
44 See supra note 12.
45 Id.
48 Compuware Corp. v. Moody’s Investors Servs., 499 F.3d 520 (6th Cir. 2007).
52 Associated Press, Doctors’ group sues state over physician rankings, Boston Herald (May 21, 2008).
53 Study Panel on Fee-For-Service Medicare, Nat’l Acad. of Social Ins., From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare (January 1998).
55 Id.
57 See Lewis G. Sandy, Driving Quality and Affordability in a Consumer-Focused World, Presentation at Center for Value-Based Insurance Design Symposium (May 1, 2007).
58 Inst. Med. supra note 5 at 93.
59 Id. at 94.
60 See National Committee for Quality Healthcare (2006), The distinction between “episodic” and “longitudinal” as used here has not gained universal acceptance. Some analysts refer to “longitudinal episodes.” For purposes of this discussion, “episodic” refers to resource use occurring over a relatively brief period of time, measured on a per-patient, per-episode basis; “longitudinal” refers to resources used in the care of a defined population over a prolonged period of time.
62 Halstead R. Holman, What should be incentivized in care of chronic illness? 3 Chronic Illness 194 (2007).
63 Supra note 20.
68 Medicare Payment Advisory Commission, Report to the Congress: Increasing the Value of Medicare (June 2006).
73 Elliott S. Fisher, Douglas O. Staiger, Julie P. Wynn, and Daniel J. Gottlieb, Creating Accountable Care Organizations: The Extended Hospital Medical Staff, (26)(1) Health Affairs (2007), http://content.healthaffairs.org/cgi/content/abstract/26/1/w44 (last visited February 16, 2009).
74 MEDPAC 2007, supra note 15.
76 Id.
77 The Medical Home model’s shared savings feature (borrowed from the PGP demonstration) should also encourage carefully considered referrals, but the model assumes rather than assures the cooperation of specialists who do not share in the add-on payment or savings bonus.