

Terminology used in physician profiling

Physician profiling is the use of physician data to determine the quality and/or cost of care provided by physicians in relation to their comparable colleagues. Many of the profiling terms used today may be unfamiliar to physicians and other health care professionals; therefore, the American Medical Association (AMA) has created this list of terminology used in physician profiling.

Attribution

Responsibility for each episode of care's actual and expected costs is attributed to physicians based on attribution rules, such as "responsibility is assigned to a physician who accounts for 30 percent or more of professional and prescribing costs" included in the episode of care. One or more physicians can be attributed for the costs of an episode of care, but if multiple physicians are attributed to that episode, they all will be assigned 100 percent of the costs of that episode of care. Attribution rules vary from health insurer to health insurer.

Case mix

Case mix, a comparison of physicians' care panels, is a process performed to account for the predisposing patient characteristics of high-risk patients and/or patients who require more care. If multiple quality measures are combined into a single physician quality performance score, case-mix adjustment should be applied to account for variation of the physician-specialty average from measure to measure. Otherwise, a physician could be penalized simply for treating patients with a certain mix of diseases.

Clinical quality measures

Evidence-based practice assumes that integrating the best research evidence and clinical expertise with clinical practice leads to optimal decision-making and patient care. Clinical quality measures have been created from best research evidence by a number of entities and are used to "rate" physicians, hospitals and other health care professionals on the care delivered to patients. There are two types of quality measures: (1) process measures, which seek to quantify the degree to which patients are receiving the "right" or appropriate treatment; and (2) outcome measures, which identify clinical end points and track indicators of improved health.

Economic profiling

"Economic profiling" is a term that denotes efforts by any entity to measure and rate physicians' relative costs of care or use of health care resources.

Economic profiling process

Health insurer economic profiling is a six-step process:

1. Claims are processed through "episode-grouper" software, which aggregates each member's claim records into episodes of care.
2. An actual cost figure is calculated for each defined episode by summing allowed amounts (or contracted rates) of all claims in the episode.

3. An episode expected cost is calculated for each defined episode, usually as the average actual cost of all episodes of the same type (e.g., all type II diabetes episodes).
4. Responsibility for each episode's actual and expected costs is attributed or assigned to a physician based on an attribution rule, such as "responsibility is assigned to the physician who accounts for 30 percent or more of professional and prescribing costs included in the episode."
5. Sums of actual costs and of expected costs are calculated for each physician based upon his or her attributed episodes.
6. A cost efficiency measure is calculated for each physician's performance.

Although physician economic profiling analyses usually include these general steps, final calculated results can differ significantly, depending upon specific methodological details.

Efficiency measurement

When payers and purchasers of health care speak of efficiency, they tend to focus on the cost or resource use of managing an episode of care (i.e., simple cost of care). Therefore, when health insurers refer to the use of efficiency metrics to measure physician performance, they are really using cost-of-care measurement systems to identify the physicians who use the least resources or incur the least costs when providing care for patients. In contrast, health economists define "efficiency" as a measure of resources required to achieve a given level of outcome (e.g., absence of pain or restoration of mobility).

Episode of care

An "episode of care" is a period of time during which a disease process is diagnosed, treated, and managed by physicians and other health care professionals. For chronic diseases, the episode of care is usually set at one calendar year. For acute conditions, the episode of care typically begins when the patient is first evaluated for the condition and ends when the care for that condition has been completed.

Grouper

Claims are processed through "episode-grouper" software, which aggregates each member's claim records into episodes of care. While groupers use different formulas, criteria and methodologies to determine cost of care, they all measure cost of care using episodes of care.

Pay for performance

The term "pay for performance" (PFP) applies to incentive programs that provide monetary bonuses or other incentives to participating physicians and other health care professionals who make progress in achieving or attaining specific quality and/or efficiency benchmarks or standards established by the program.

Public reporting

Public reporting is publicizing the scores of physicians' ratings that are based on their performance in meeting quality or efficiency (cost) benchmarks.

Quality measurement

Quality measurement, usually based on claims or administrative data, attempts to determine physicians' success in meeting quality measures established by the physician-profiling program. Some of the issues associated with quality measurement include who establishes the process or outcome and how the process and outcome are measured.

Resource use

“Resource use” refers to the number and type of services provided to a patient in an episode of care. Cost of service refers to the total cost of services provided to a patient for an episode of care. Either cost or resource use can be used when trying to determine physician efficiency. When resource use is used, a standardized cost for each service is applied, regardless of the actual cost of each service. Some argue that measuring physician efficiency based on resource use provides a better indication of true physician efficiency in the care of patients because variable factors (e.g., physician fee schedule, actual charges for laboratory and other tests, and cost of the hospital room) do not affect the ratings.

Risk assessment

Risk assessment is a method used to evaluate the predicted overall health care claim dollars for each of the health insurer’s members relative to the average member in a patient given population. It is common to refer to a particular risk assessment method as a “risk adjuster.” There are two types of health risk assessment models: (1) prospective or predictive models, which use data from a previous year to estimate future expenses and set health insurance premium rates for a given member population; and (2) concurrent models, which draw on data collected in the current year to explain expenses in the same period. Typically, health insurers use concurrent models to profile physicians and other health care professionals because these models capture more of the costs of actual utilization during a year, while prospective models only make predictions of future utilization.

The risk assessment process entails feeding health care claims data, which may be supplemented by data from pharmacies, laboratories and member-reported information, into risk-modeling computer programs. The methodology that these models use to predict risk and/or determine costs of care varies, but all modeling software produces a relative risk score for each member of the population when the data of that population are run through the software. The relative risk score demonstrates the predicted risk or predicted costs of care to the payer. The relative risk score might also be used to predict the relative health risk of patients in a particular physician’s practice.

A relative risk score of 1.0 means the member is predicted to incur average health care costs for the next year. A score above 1.0 means the member is at risk for incurring higher-than-average costs, and a score lower than 1.0 means the member has a lower-than-average risk. The risk score may be based on the age and gender of the member, the burden of illness (the type and number of illnesses), and indirect and trend factors, such as how many times the member was seen in the emergency room, the number of times the member was admitted to the hospital or the number of physicians treating the member.

Risk adjustment

Risk adjustment is the process of adjusting payments to health insurers or physicians and other health care professionals in order to reflect the differences in member risk, as measured by the health insurer’s risk assessment of the individual member. Accurate risk adjustment is critical; otherwise, health insurers, physicians and other health care professionals would have an incentive to provide services only to relatively young, healthy people and to avoid older or sicker people. The risk-adjustment component of economic profiling models frequently does not take into account all of the member factors that must be considered for valid risk adjustment. There are no scientific studies to validate the accuracy of risk-adjustment methodologies for physician profiling. If risk calculations do not control for differences in severity, complexity, treatment compliance and demographic characteristics among the patient population, health insurers and physicians providing services for the sicker, more complicated or more difficult-to-manage patients may be penalized.

Sample size

When measuring physician “efficiency” or cost of care, sample size is a key variable. The larger the number of patient records (“n”) used to create the physician profile, the more accurate the results are. A rating based on data from 50 cases is far more likely to be reliable than a rating based on five cases, in which one aberrant case

can dramatically affect the results. Available administrative data for a single health insurer limits the ability to capture information on a physician's entire panel of patients and may provide insufficient information for benchmarking performance for individual physicians.

Tiered and narrow networks

Primarily established by health insurers, tiered and narrow networks are generally based on cost-of-care factors and sometimes in conjunction with the quality of those services or health outcomes. In tiered networks, health insurers assign physicians to two or more separate tiers, whereas narrow networks offer only one smaller select group of physicians that the patient must see. Tiered networks use either co-payments/co-insurance differentials or other incentives to try to steer patients to physicians in the least costly tier. Depending on how many physicians remain in the preferred network, access and other health care problems may be exacerbated.

Value-based purchasing

Value-based purchasing is an incentive approach to health care purchasing. Organizations that ascribe to the value-based purchasing model work toward a common goal to ensure that consumers have access to publicly reported health-care-performance and cost-of-care information so consumers can make informed decisions about their care. Purchasers of health care services hold health insurers accountable for meeting certain quality and/or efficiency (cost-of-care) standards, even terminating contracts with those health insurers that fail to meet employers' benchmarks.

Questions or concerns about practice management issues?

The AMA has developed various resources and tools to aid physicians and their practice staff in developing strategies for influencing payers to make policies fair and clinically appropriate. Visit the AMA's Web site at www.ama-assn.org/go/pfp to access these resources. AMA members and their practice staff may e-mail the AMA Practice Management Center at practicemanagementcenter@ama-assn.org for assistance.

For additional information and resources, there are three easy ways to contact the AMA Practice Management Center:

- Call **(800) 262-3211** and ask for the AMA Practice Management Center.
- Fax information to **(312) 464-5541**.
- Visit www.ama-assn.org/go/pmc to access the AMA Practice Management Center Web site.

The Practice Management Center is a resource of the AMA Private Sector Advocacy unit.