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Physician Tiering: Efficiency Rating or Economic Profiling?

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In an ever-changing market where the cost of healthcare is skyrocketing, a novel method to control health-care costs is “physician tiering.”

In an attempt to marry cost and quality “efficiency,” the largest consumer of healthcare for the state of Massachusetts, the Group Insurance Commission (GIC), contracted with independent consulting firm Symmetry Health to use a proprietary technology they had developed, “Episode Treatment Groups” (ETGs), to categorize physicians into various classes ~ or “tiers” ~ depending on how efficiently they used resources to manage a particular episode or problem. The most significant criteria in this particular methodology are the cost of delivering care and the rating of a physician as more “efficient” if he/she is able to achieve the same outcome as another physician at a lower cost.

The concept of lower-cost healthcare or cost-effective healthcare is not novel. With the increasing burden in the cost of healthcare both to the consumer and to the payor, it becomes incumbent on all who participate in the healthcare system to help responsibly manage assets and exercise fiduciary restraint on the utilization of resources. When tiering was introduced, physicians were opposed to the methodology and therefore were viewed as being against any form of quality improvement or cost constraints.

Proponents of the current tiering system would argue that given the need to manage resources efficiently, consumers of healthcare should be given the option of choosing to have their care provided by a "more efficient" physician, ie one who is able to provide the same outcome at a lower cost than another physician in the same specialty and geographic location. Further, a number of consumers feel that they do not have the option to delay rising deductibles, co-insurance, and co-pays until perfect physician cost and quality measurement data is available. The inaffordability of rising healthcare costs makes it contingent on the healthcare system to provide any and all information to its consumers so that they can make informed decisions, albeit based on cost as a significant criterion.

Opponents of the tiering system argue that the current methodology of measurement uses claims-based data which was only intended to provide a basis for reimbursement for services, not to represent the quality of the healthcare delivered. Consequently, there are serious limitations and opportunities for inaccuracies when using administrative data submitted primarily for reimbursement purposes to determine the quality and efficiency of care provided by physicians. The current methodology being used has several limitations, the most significant being the definition of a physician specialty, the attribution of an expected cost to an episode, the sample size in terms of the number of episodes being evaluated, and attribution rules such as which physician takes

responsibility for the major costs in an episode given that care to a patient is provided by a multitude of physicians representing a variety of specialties.

In addition to the inaccuracies of developing the ETG-based system of tiering, there are other difficulties with the concept as developed. Physicians with no prior practice history are placed in a higher tier by default. Thus, physicians in the same group may be in different tiers, purely because of the presence or absence of prior practice history. Of greater significance, new graduates starting a practice would be placed in a higher tier, making it virtually impossible for them to grow and survive in practice. Further, by having physicians within the same group belong to different tiers, patients would be left with the uncomfortable dilemma of having to break established relationships in order to migrate to a physician in a lower tier, even if that physician is a colleague in the same group. Lastly, in specialties where there is a relative dearth of physicians, patients would be forced to pay a higher premium to see such physicians irrespective of their tier due to geographic or other constraints.

For these and many other reasons, physicians and other healthcare providers are concerned about the potential disruption to longitudinal care that this may represent, with all of its unintended consequences. Additionally, a number of health plans that contemplated following GIC's footsteps have hastily rescinded their plans for implementation in response to such concerns.

In summary, the concept of cost constraints and improved efficiency in the delivery of healthcare is absolutely vital to the survival of the healthcare system. There is no doubt that the advent of electronic technology, access to evidence-based resources on the web and attempts to create "electronic communities" between physician offices and hospitals so as to prevent duplication of resources all represent major advances in the efficiency and safety of the healthcare system. To that effect, any reluctance by physicians to embrace such progress would be viewed as unjustified. However, in the absence of such a "perfect" world, using whatever imperfect methodology exists to come to those same conclusions in efficiency and quality in the absence of a rigorous and transparent methodology runs the risk of creating further constraints on healthcare resources and an inequitable burden on consumers of healthcare.

As we stand on the threshold of a challenging and "stressful" time in the healthcare system in the US today, I am reminded of the words of Henry Wadsworth Longfellow:

"It's not joy and not sorrow that's our destined end or way
But to find that each tomorrow finds us further than today."