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MEDICARE SPENDING

Preliminary Findings Regarding an Approach Focusing on Physician Practice Patterns to Foster Program Efficiency

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Highlights of [GAO-07-567T](#), a testimony before the Subcommittee on Health, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

Medicare's current system of spending targets used to moderate spending growth for physician services and annually update physician fees is problematic. This spending target system—called the sustainable growth rate (SGR) system—adjusts physician fees based on the extent to which actual spending aligns with specified targets. In recent years, because spending has exceeded the targets, the system has called for fee cuts. Since 2003, the cuts have been averted through administrative or legislative action, thus postponing the budgetary consequences of excess spending. Under these circumstances, policymakers are seeking reforms that can help moderate spending growth while ensuring that beneficiaries have appropriate access to care. For today's hearing, this subcommittee, which is exploring options for improving how Medicare pays physicians, asked GAO to share the preliminary results of its ongoing study related to this topic.

GAO's statement addresses (1) approaches taken by other health care purchasers to address physicians' inefficient practice patterns, (2) GAO's efforts to estimate the prevalence of inefficient physicians in Medicare, and (3) the methodological tools available to identify inefficient practice patterns programwide. GAO ensured the reliability of the claims data used in this report by performing appropriate electronic data checks and by interviewing agency officials who were knowledgeable about the data.

www.gao.gov/cgi-bin/getrpt?GAO-07-567T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact A. Bruce Steinwald at (202) 512-7101 or steinwalda@gao.gov.

MEDICARE SPENDING

Preliminary Findings Regarding an Approach Focusing on Physician Practice Patterns to Foster Program Efficiency

What GAO Found

Consistent with the premise that physicians play a central role in the generation of health care expenditures, some health care purchasers examine the practice patterns of physicians in their network to promote efficiency. GAO selected 10 health care purchasers for review because they assess physicians' performance against an efficiency standard. To measure efficiency, the purchasers we spoke with generally compared actual spending for physicians' patients to the expected spending for those same patients, given their clinical and demographic characteristics. Most purchasers said they also evaluated physicians on quality. The purchasers linked their efficiency analysis results and other measures to a range of strategies—from steering patients toward the most efficient providers to excluding a physician from the purchaser's provider network because of poor performance. Some of the purchasers said these efforts produced savings.

Having considered the efforts of other health care purchasers in evaluating physicians for efficiency, GAO conducted its own analysis of physician practices in Medicare. GAO used the term efficiency to mean providing and ordering a level of services that is sufficient to meet patients' health care needs but not excessive, given a patient's health status. GAO focused the analysis on generalists—physicians who described their specialty as general practice, internal medicine, or family practice—and selected metropolitan areas that were diverse geographically and in terms of Medicare spending per beneficiary. GAO found that individual physicians who were likely to practice medicine inefficiently were present in each of 12 metropolitan areas studied.

The Centers for Medicare & Medicaid Services (CMS), the agency that administers Medicare, also has the tools to identify physicians who are likely to practice medicine inefficiently. Specifically, CMS has at its disposal comprehensive medical claims information, sufficient numbers of physicians in most areas to construct adequate sample sizes, and methods to adjust for differences in beneficiary health status.

A primary virtue of examining physician practices for efficiency is that the information can be coupled with incentives that operate at the individual physician level, in contrast with the SGR system, which operates at the aggregate physician level. Efforts to improve physician efficiency would not, by themselves, be sufficient to correct Medicare's long-term fiscal imbalance, but such efforts could be an important part of a package of reforms aimed at future program sustainability.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss options for improving how Medicare pays physicians. Your task is not simple, as you seek reforms that can help moderate spending growth while ensuring that beneficiaries have appropriate access to high-quality physician services and physicians receive fair compensation for providing those services. Medicare's current system of spending targets used to moderate spending growth and annually update physician fees is problematic.

This spending target system—called the sustainable growth rate (SGR) system—adjusts Medicare's physician fees based on the extent to which actual spending aligns with specified targets. If the growth in the number of services provided per beneficiary—referred to as volume—and in the average complexity and costliness of services—referred to as intensity—is high enough, spending will exceed the SGR target. From 1999—the first year that the SGR system was used to update physician fees—through 2001, physicians received fee increases annually. Since 2002, actual Medicare spending on physician services has exceeded SGR targets, and the SGR system has called for fee cuts to offset the excess spending. In 2002 the SGR system reduced physician fees by nearly 5 percent. Fee declines in subsequent years were averted only by administrative and legislative actions that modified or temporarily overrode the SGR system.¹ In the absence of additional administrative or legislative action, the SGR system will likely reduce fees by about 5 percent a year for the next several years.

The potential for a sustained period of declining fees has raised policymakers' concerns about the appropriateness of the SGR system for updating physician fees and about physicians' continued participation in the Medicare program. A particular concern is that the SGR system acts as a blunt instrument in that all physicians are subject to the consequences of excess spending—namely, downward fee adjustments—that may stem from the excessive use of resources by only some physicians. However, as we have discussed in our prior work, the SGR system serves an important

¹For example, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) specified a minimum update of 1.5 percent for both 2004 and 2005. Pub. L. No. 108-173, § 601(a)(1), 117 Stat. 2066, 2300.

role in alerting policymakers to the need for fiscal discipline.² Specifically, fee cuts under the SGR system signal to physicians collectively and to the Congress that spending due to volume and intensity has increased more than allowed.

Some of the higher volume and intensity that drives spending growth may not be medically necessary. In fact, the wide geographic variation in Medicare spending per beneficiary—unrelated to beneficiary health status or outcomes—provides evidence that health needs alone do not determine spending.³ Medicare physician payment policy does little to change this situation; payments under the Medicare program are not designed to foster individual physician responsibility for the most effective medical practices. In contrast, some public and private health care purchasers have initiated programs to identify efficient physicians and encourage patients to obtain care from these physicians.

With these circumstances in mind, and in fulfillment of a 2003 mandate to examine aspects of physician compensation in Medicare,⁴ we conducted a study focusing on efficiency with respect to physician practices. In our study, we use the term efficiency to mean providing and ordering a level of services that is sufficient to meet a patient's health care needs but not excessive, given a patient's health status. My remarks today will address (1) physician-focused approaches taken by other health care purchasers to address inefficient medical practices, (2) our efforts to estimate the prevalence of inefficient physicians in Medicare, and (3) the methodological tools available to the Centers for Medicare & Medicaid Services (CMS) to identify inefficient physician practice patterns programwide. My remarks today are based on our study's preliminary findings.

²GAO, *Medicare Physician Payments: Trends in Service Utilization, Spending, and Fees Prompt Consideration of Alternative Payment Approaches*, [GAO-06-1008T](#) (Washington, D.C.: July 25, 2006) and *Medicare Physician Payments: Concerns about Spending Target System Prompt Interest in Considering Reforms*, [GAO-05-85](#) (Washington, D.C.: Oct. 8, 2004).

³Elliot S. Fisher, et al., "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," *Annals of Internal Medicine*, vol. 138, no. 4 (2003): 273-287.

⁴MMA, Pub. L. No. 108-173, § 953, 117 Stat. 2066, 2428.

In conducting our study, we interviewed representatives of 10 health care purchasers,⁵ including 5 commercial health plans, 1 provider network, 1 trust fund jointly managed by employers and a union, and 3 government agencies—2 in U.S. states and 1 in a Canadian province. We selected these purchasers because their programs that examine physician practices explicitly assess efficiency—unlike many such programs that assess quality only. We also estimated the prevalence in Medicare of physicians likely to practice inefficiently. To do this work, we examined 2003 Medicare claims data from 12 metropolitan areas. We ensured the reliability of the claims data used in this report by performing appropriate electronic data checks and by interviewing officials at CMS who were knowledgeable about the data. In addition, we discussed the facts contained in this statement with CMS officials. The study on which these remarks are based has been conducted beginning September 2005 in accordance with generally accepted government auditing standards.

In summary, the health care purchasers we studied examined the practice patterns of physicians in their networks and used the results to promote efficiency. They adopted a range of incentives—from steering patients toward the most efficient providers to excluding a physician from the network—to encourage physicians to provide care efficiently; some reported savings as a result of these efforts. Using our own methodology to analyze the practice patterns of physicians in Medicare, we found that physicians who were likely to be practicing medicine inefficiently were present in all 12 of the metropolitan areas studied. CMS also has the tools to identify physicians in Medicare who are likely to practice medicine inefficiently, including comprehensive claims information, sufficient numbers of physicians in most areas to construct adequate sample sizes, and methods to adjust for differences in beneficiary health status.

⁵In our study, we use “purchaser” to mean health plans as well as agencies that manage care purchased from health plans; one of the entities we interviewed is a provider network that contracts with several insurance companies to provide care to their enrollees.

Some Health Care Purchasers Use Physician Profiling Results to Encourage Efficient Medical Practice

Consistent with the premise that physicians play a central role in the generation of most health care expenditures, some health care purchasers employ physician profiling to promote efficiency. We selected 10 health care purchasers that profiled physicians in their networks—that is, compared physicians’ performance to an efficiency standard to identify those who practiced inefficiently. To measure efficiency, the purchasers we spoke with generally compared actual spending for physicians’ patients to the expected spending for those same patients, given their clinical and demographic characteristics.⁶ Most purchasers said they also evaluated physicians on quality. The purchasers linked their efficiency profiling results and other measures to a range of physician-focused strategies to encourage the efficient provision of care. Some of the purchasers said their profiling efforts produced savings.

Health Care Purchasers Profiled Physicians across Several Dimensions to Evaluate Physician Performance

The 10 health care purchasers we examined used two basic profiling approaches to identify physicians whose medical practices were inefficient. One approach focused on the costs associated with treating a specific episode of illness—such as a stroke or heart attack. The other approach focused on costs, within a specific period, associated with the patients in a physician’s practice. Both approaches used information from medical claims data to measure resource use and account for differences in patients’ health status. In addition, both approaches assessed physicians (or physician groups) based on the costs associated with services that they may not have provided directly, such as costs associated with a hospitalization or services provided by a different physician.

Although the methods used by purchasers to predict patient spending varied, all used patient demographics and diagnoses. The methods they used generally computed efficiency measures as the ratio of actual to expected spending for patients of similar health status. In addition, all of the purchasers we interviewed profiled specialists and all but one also profiled primary care physicians. Several purchasers said they would only profile physicians who treated an adequate number of cases, since such analyses typically require a minimum sample size to be valid.

⁶Generally, estimates of an individual’s expected spending are based on factors such as patient diagnoses and demographic traits.

Health Care Purchasers Linked Physician Profiling Results to a Range of Incentives Encouraging Efficiency

The health care purchasers we examined directly tied the results of their profiling methods to incentives that encourage physicians in their networks to practice efficiently. The incentives varied widely in design, application, and severity of consequences. Purchasers used incentives that included

- educating physicians to encourage more efficient care,
- designating in their physician directories those physicians who met efficiency and quality standards,
- dividing physicians into tiers based on efficiency and giving enrollees financial incentives to see physicians in particular tiers,
- providing bonuses or imposing penalties based on efficiency and quality standards, and
- excluding inefficient physicians from the network.

Physician Profiling Has Potential for Savings

Evidence from our interviews with the health care purchasers suggests that physician profiling programs may have the potential to generate savings for health care purchasers. Three of the 10 purchasers reported that the profiling programs produced savings and provided us with estimates of savings attributable to their physician-focused efficiency efforts. For example, 1 of those purchasers reported that growth in spending fell from 12 percent to about 1 percent in the first year after it restructured its network as part of its efficiency program, and an actuarial firm hired by the purchaser estimated that about three quarters of the reduction in expenditure growth was most likely a result of the efficiency program. Three other purchasers suggested their programs might have achieved savings but did not provide savings estimates, while four said they had not attempted to measure savings at the time of our interviews.

Through Profiling, We Found That Physicians Likely to Practice Inefficiently in Medicare Were Present in All Selected Areas

Having considered the efforts of other health care purchasers in profiling physicians for efficiency, we conducted our own profiling analysis of physician practices in Medicare and found individual physicians who were likely to practice medicine inefficiently in each of 12 metropolitan areas studied. We focused our analysis on generalists—physicians who described their specialty as general practice, internal medicine, or family practice. We did not include specialists in our analysis. We selected areas that were diverse geographically and in terms of Medicare spending per beneficiary.

Under our methodology, we computed the percentage of overly expensive patients in each physician's Medicare practice. To identify overly expensive patients, we grouped the Medicare beneficiaries in the 12 locations according to their health status, using diagnosis and demographic information. Patients whose total Medicare expenditures—for services provided by all health providers, not just physicians—far exceeded those of other patients in their same health status grouping were classified as overly expensive. Once these patients were identified and linked to the physicians who treated them, we were able to determine which physicians treated a disproportionate share of these patients compared with their generalist peers in the same location. We classified these physicians as outliers—that is, physicians whose proportions of overly expensive patients would occur by chance less than 1 time in 100. We concluded that these outlier physicians were likely to be practicing medicine inefficiently.⁷

Based on 2003 Medicare claims data, our analysis found outlier generalist physicians in all 12 metropolitan areas we studied. In two of the areas, outlier generalists accounted for more than 10 percent of the area's generalist physician population. In the remaining areas, the proportion of outlier generalists ranged from 2 percent to about 6 percent of the area's generalist population.

⁷Our approach to estimating outlier physicians was conservative in that it captures only the most extreme practice patterns; therefore, our analysis does not mean that all nonoutlier physicians were practicing efficiently.

CMS Has Tools Available to Profile Physicians for Efficiency

Medicare's data-rich environment is conducive to identifying physicians who are likely to practice medicine inefficiently. Fundamental to this effort is the ability to make statistical comparisons that enable health care purchasers to identify physicians practicing outside of established standards. CMS has the tools to make statistically valid comparisons, including comprehensive medical claims information, sufficient numbers of physicians in most areas to construct adequate sample sizes, and methods to adjust for differences in patient health status.

Among the resources available to CMS are the following:

- *Comprehensive source of medical claims information.* CMS maintains a centralized repository, or database, of all Medicare claims that provides a comprehensive source of information on patients' Medicare-covered medical encounters. Using claims from the central database, each of which includes the beneficiary's unique identification number, CMS can identify and link patients to the various types of services they received and to the physicians who treated them.
- *Data samples large enough to ensure meaningful comparisons across physicians.* The feasibility of using efficiency measures to compare physicians' performance depends, in part, on two factors: the availability of enough data on each physician to compute an efficiency measure and numbers of physicians large enough to provide meaningful comparisons. In 2005, Medicare's 33.6 million fee-for-service enrollees were served by about 618,800 physicians. These figures suggest that CMS has enough clinical and expenditure data to compute efficiency measures for most physicians billing Medicare.
- *Methods to account for differences in patient health status.* Because sicker patients are expected to use more health care resources than healthier patients, the health status of patients must be taken into account to make meaningful comparisons among physicians. Medicare has significant experience with risk adjustment. Specifically, CMS has used increasingly sophisticated risk adjustment methodologies over the past decade to set payment rates for beneficiaries enrolled in managed care plans.

To conduct profiling analyses, CMS would likely make methodological decisions similar to those made by the health care purchasers we interviewed. For example, the health care purchasers we spoke with made choices about whether to profile individual physicians or group practices; which risk adjustment tool was best suited for a purchaser's physician and enrollee population; whether to measure costs associated with episodes of

care or the costs, within a specific time period, associated with the patients in a physician's practice; and what criteria to use to identify inefficient practice patterns.

Concluding Observations

Our experience in examining what health care purchasers other than Medicare are doing to improve physician efficiency and in analyzing Medicare claims has enabled us to gain some insights into the potential of physician profiling to improve Medicare program efficiency. A primary virtue of profiling is that, coupled with incentives to encourage efficiency, it can create a system that operates at the individual physician level. In this way, profiling can address a principal criticism of the SGR system, which only operates at the aggregate physician level. Although savings from physician profiling alone would clearly not be sufficient to correct Medicare's long-term fiscal imbalance, it could be an important part of a package of reforms aimed at future program sustainability.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions you or the subcommittee members may have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please contact A. Bruce Steinwald at (202) 512-7101 or at steinwalda@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions include James Cosgrove and Phyllis Thorburn, Assistant Directors; Todd Anderson; Alex Dworkowitz; Hannah Fein; Gregory Giusto; Richard Lipinski; and Eric Wedum.

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