

# **ECONOMIC PROFILING OF PHYSICIANS: WHAT IS IT?**

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A large and increasing number of health plans now use provider performance Web sites to make measures of physician cost efficiency available to health plan members, expecting that members will consult the data when selecting physicians for care. It is also increasingly common for health plans to use cost-efficiency data to partition physician networks into performance tiers, and then use differential co-payment or co-insurance rates to motivate health plan members to utilize physicians identified as cost efficient and to avoid physicians identified as cost inefficient.

Typically, all diagnostic and therapeutic services received by a health plan member – physician office visits, laboratory tests, imaging examinations, prescribed medications, office- and facility-based procedures, inpatient facility stays, physical therapy, etc. – result in claim forms being submitted to the health plan. Claims are submitted whether or not the plan, because of benefit limitations and co-payment and deductible requirements, ultimately pays all, some, or none of the service cost. Health plans view their claim databases as comprehensive records of services received by patients. (Physicians, on the other hand, typically consider patient charts to be the only reliable source for such information.) Because claim data, stored in electronic form, are easily accessible for analysis, health plans regard the databases as ideal resources for information on the physicians providing care to their members.

The following steps are used by health plans to extract cost efficiency measures from their claim databases:

1. Claims are processed through “episode grouper” software, which aggregates each member’s claim records into “episodes of care,” where an episode of care refers to a period during which a disease process is present and is being managed – diagnosed and treated – by health care providers.<sup>1</sup>

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<sup>1</sup> Examples of types of episodes include septicemia, acute bronchitis, viral meningitis, congestive heart failure, emphysema, and malignant neoplasm of the prostate. Episodes are defined for short duration conditions, such as acute bronchitis, and chronic conditions, such as congestive heart failure. At different times during the period covered by a claim database (e.g., one year) a patient might experience multiple episodes of the same type (e.g., viral skin infection episodes), and at any point in time the patient might be experiencing several different types of episodes (e.g., acute bronchitis, congestive heart failure).

2. An actual cost figure is calculated for each defined episode by summing allowed amounts<sup>2</sup> of all claims included in the episode, including those for physician services, inpatient and outpatient facility services, prescription medications, and other services.
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 acute sinusitis episodes, all type II diabetes episodes).
4. Responsibility for each episode's actual and expected costs is attributed to a physician based on an attribution rule such as: "responsibility is assigned to the physician who accounts for 30% 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 (e.g., ratio of total actual to total expected costs) is calculated for each physician, and physicians are compared, within specialty, on relative cost efficiency performance.

Although physician economic profiling analyses almost always include these general steps, final calculated results can differ significantly depending upon specific methodological details. Among important methodological issues are rules used for attributing responsibility for specific episodes of care to individual physicians, and the minimum number of attributed episodes that must be available before a physician's cost efficiency score can be calculated. The different ways in which payers handle these issues can help explain how physicians can be evaluated as efficient by one payer and inefficient by another.

To view Dr. Thomas' more comprehensive AMA paper on cost efficiency measurement, "ECONOMIC PROFILING OF PHYSICIANS: WHAT IS IT? HOW IS IT DONE? WHAT ARE THE ISSUES?" go to the AMA Private Sector Advocacy Web page at [www.ama-assn.org/go/pfp](http://www.ama-assn.org/go/pfp).

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<sup>2</sup> A health plan claim usually includes three separate cost fields: (1) charge amount, the fee listed by the service provider as the charge for the service; (2) allowed amount, the amount contractually agreed upon by the health plan and the provider as payment for the service; and (3) paid amount, the amount actually paid by the health plan after subtracting patient payments for deductibles, co-payments, and co-insurance. In economic profiling of physicians, allowed amount is used in cost efficiency calculations.