

GAO

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MEDICARE

Providing Systematic
Feedback to Physicians on
their Practice Patterns Is a
Promising Step Toward
Encouraging Program
Efficiency

Statement of A. Bruce Steinwald
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Highlights of [GAO-07-862T](#), a testimony before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

GAO was asked to discuss—based on *Medicare: Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency*, [GAO-07-307](#) (Apr. 30, 2007)—the importance in Medicare of providing feedback to physicians on how their use of health care resources compares with that of their peers. GAO's report discusses an approach to analyzing physicians' practice patterns in Medicare and ways the Centers for Medicare & Medicaid Services (CMS) could use the results. In a related matter, Medicare's sustainable growth rate system of spending targets used to moderate physician spending growth and annually update physician fees has been problematic, acting as a blunt instrument and lacking in incentives for physicians individually to be attentive to the efficient use of resources in their practices. GAO's statement focuses on (1) the results of its analysis estimating the prevalence of inefficient physicians in Medicare and (2) the potential for CMS to profile physicians in traditional fee-for-service Medicare for efficiency and use the results in ways that are similar to other purchasers' efforts to encourage efficiency.

What GAO Recommends

In its report, GAO recommended that CMS develop a system that identifies individual physicians with inefficient practice patterns and, seeking legislative authority as necessary, uses the results to improve program efficiency.

www.gao.gov/cgi-bin/getrpt?GAO-07-862T.

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

Providing Systematic Feedback to Physicians on their Practice Patterns Is a Promising Step Toward Encouraging Program Efficiency

What GAO Found

Having considered efforts of 10 private and public health care purchasers that routinely evaluate physicians for efficiency and other factors, GAO conducted its own analysis of physician practices in Medicare. 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. Although GAO did not include specialists in its analysis, its method does not preclude profiling specialists, as long as enough data are available to make meaningful comparisons across physicians. Based on 2003 Medicare claims data, GAO's analysis found outlier generalist physicians—physicians who treat a disproportionate share of overly expensive patients—in all 12 metropolitan areas studied. Outlier generalists and other generalists saw similar numbers of Medicare patients and their respective patients averaged the same number of office visits. However, 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 more likely to have been hospitalized, more likely to have been hospitalized multiple times, and more likely to have used home health services. By contrast, they were less likely to have been admitted to a skilled nursing facility. GAO concluded that outlier generalists were likely to practice medicine inefficiently.

CMS has tools available to evaluate physicians' practices for efficiency, including a comprehensive repository of Medicare claims data to compute reliable efficiency measures and substantial experience adjusting for differences in patients' health status. The agency also has wide experience in conducting educational outreach to physicians with respect to improper billing practices and potential fraud—providing individual physicians, in some cases, comparative information on how the physician varies from other physicians in the same specialty or in other ways. A physician education effort based on efficiency profiling would therefore not be a foreign concept in Medicare. For example, CMS could provide physicians a report that compares their practice's efficiency with that of their peers, enabling physicians to see whether their practice style is outside the norm. As for implementing other strategies to encourage efficiency, such as the use of certain financial incentives, CMS would likely need additional legislative authority.

CMS agreed with the need to measure physician resource use in Medicare but raised concerns about the costs involved in reporting the results and was silent on other strategies discussed beyond physician education. GAO concurs that resource use measurement and reporting activities would require adequate funding; however, GAO is concerned that efforts to achieve efficiency that rely solely on physician education without financial or other incentives for physicians to curb inefficiencies will be suboptimal.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss the importance of physician-focused strategies to improve efficiency in Medicare. One such strategy entails providing feedback to physicians on how their use of health care resources compares with that of their peers. We recently issued a report, entitled *Medicare: Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency*,¹ which discusses an approach to analyzing physicians' practice patterns in Medicare and ways the Centers for Medicare & Medicaid Services (CMS)² could use the results of such an analysis to modify inefficient physician behavior. In the report, we used 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.

The report fulfilled a 2003 mandate that we examine aspects of physician compensation in Medicare, pertaining only to physicians serving beneficiaries in traditional fee-for-service (FFS) Medicare.³ This topic has been of significant interest to the Congress, as Medicare's current system of spending targets used to moderate physician spending growth and annually update physician fees has been 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. In recent years, the SGR system has called for cuts in physician fees to offset volume and intensity increases that have exceeded spending targets. Although these cuts have been overridden by legislative or administrative action, a sustained period of declining fees under the SGR system is projected. Policymakers are therefore concerned about the appropriateness of the SGR system for updating physician fees and about physicians' continued participation in the Medicare program. The problem, in part, is that the SGR system acts as a blunt instrument in that all physicians are subject to the consequences of

¹[GAO-07-307](#) (Washington, D.C.: Apr. 30, 2007).

²CMS is the agency that administers Medicare.

³See Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, § 953, 117 Stat. 2066, 2428.

excess spending—namely, downward fee adjustments—that may stem from the excessive use of resources by only some physicians. In addition, under the SGR system, individual physicians have no incentive to be attentive to the efficient use of resources in their own practices.

Policymakers are also concerned that some of the increase in volume and intensity that drives spending growth may not be medically necessary. Experts agree that physicians play a central role in the generation of health care expenditures in total.⁴ For example, physicians refer patients to other physicians; they admit patients to hospitals, skilled nursing facilities, and hospices; and they order services delivered by other health care providers, such as imaging studies, laboratory tests, and home health services. However, some of the spending for services provided and ordered by physicians may not be warranted. For example, 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.⁵ 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 them.

Against this backdrop, my remarks today will focus on (1) the results of our analysis estimating the prevalence of inefficient physicians in Medicare and (2) the potential for CMS to profile physicians in traditional FFS Medicare for efficiency and use the results in ways that are similar to other purchasers' efforts to encourage efficiency. My remarks are based on findings in our report: *Medicare: Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency*.⁶ Having considered the efforts of 10 private and public health care purchasers that routinely evaluate physicians for efficiency and other factors, we conducted our own analysis

⁴GAO, *Comptroller General's Forum on Health Care: Unsustainable Trends Necessitate Comprehensive and Fundamental Reforms to Control Spending and Improve Value*, [GAO-04-793SP](#) (Washington D.C.: May 1, 2004); Laura A. Dummit, *Medicare Physician Payments and Spending*, National Health Policy Forum, Issue Brief Number 815 (Washington D.C.: Oct. 9, 2006).

⁵Elliot 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.

⁶[GAO-07-307](#).

of physician practices in Medicare. We 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. Although we did not include specialists in the analysis, our method does not preclude profiling specialists, as long as enough data are available to make meaningful comparisons across physicians. We based our analysis on 2003 Medicare claims data. We conducted our work from September 2005 through May 2007 in accordance with generally accepted government auditing standards.

In summary, we found outlier generalist physicians—physicians who treat a disproportionate share of overly expensive patients—in all 12 metropolitan areas studied. Outlier generalists and other generalists saw similar numbers of Medicare patients and their respective patients averaged the same number of office visits. However, after taking health status and location into account, we found that Medicare patients who saw an outlier generalist—compared with those who saw other generalists—were more likely to have been hospitalized, more likely to have been hospitalized multiple times, and more likely to have used home health services. By contrast, they were less likely to have been admitted to a skilled nursing facility. We concluded that outlier generalists were likely to practice medicine inefficiently.

CMS has tools available to evaluate physicians' practices for efficiency, including a comprehensive repository of Medicare claims data to compute reliable efficiency measures and substantial experience adjusting for differences in patients' health status. The agency also has wide experience in conducting educational outreach to physicians with respect to improper billing practices and potential fraud—providing individual physicians, in some cases, comparative information on how the physician varies from other physicians in the same specialty or in other ways. A physician education effort based on efficiency profiling results would therefore not be a foreign concept in Medicare. For example, CMS could provide physicians a report that compares their practice's efficiency with that of their peers, enabling physicians to see whether their practice style is outside the norm. As for implementing other strategies to encourage efficiency, such as the use of certain financial incentives, CMS would likely need additional legislative authority.

In our April 2007 report, we recommended that CMS develop a system that identifies individual physicians with inefficient practice patterns and, seeking legislative changes as necessary, uses the results to improve program efficiency. CMS agreed with the need to measure physician resource use in Medicare but raised concerns about the costs involved in reporting the results and was silent on other strategies discussed beyond physician education. We concur that resource use measurement and reporting activities would require adequate funding; however, we are concerned that efforts to achieve efficiency that rely solely on physician education without financial or other incentives for physicians to curb inefficiencies will be suboptimal.

Background

Linking efficiency to physician payment policy has been a subject of interest among policymakers and health policy analysts. For example, the Institute of Medicine has recently recommended that Medicare payment policies should be reformed to include a system for paying health care providers differentially based on how well they meet performance standards for quality or efficiency or both.⁷ In April 2005, CMS initiated a demonstration mandated by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) to test this approach.⁸ Under the Physician Group Practice demonstration, 10 large physician group practices, each comprising at least 200 physicians, are eligible for bonus payments if they meet quality targets and succeed in keeping the total expenditures of their Medicare population below annual targets.⁹

Several studies have found that Medicare and other purchasers could realize substantial savings if a portion of patients switched from less efficient to more efficient physicians. The estimates vary according to assumptions about the proportion of beneficiaries changing physicians.¹⁰ In 2003, the Consumer-Purchaser Disclosure Project, a partnership of consumer, labor, and purchaser organizations, asked actuaries and health

⁷Institute of Medicine, *Rewarding Provider Performance: Aligning Incentives in Medicare (Pathways to Quality Health Care Series) – Summary* (Washington, D.C.: 2007).

⁸Pub. L. No. 106-554, app. F, § 412(a), 114 Stat. 2763, 2763A–509-515.

⁹We are currently conducting a study of the demonstration, as required by BIPA (Pub. L. No. 106-554, app. F, § 412(b), 114 Stat. 2763, 2763A–515).

¹⁰See Consumer-Purchaser Disclosure Project, *More Efficient Physicians: A Path to Significant Savings in Health Care* (Washington, D.C.: July 2003).

researchers to estimate the potential savings to Medicare if a small proportion of beneficiaries started using more efficient physicians. The Project reported that Medicare could save between 2 and 4 percent of total costs if 1 out of 10 beneficiaries moved to more efficient physicians. This conclusion is based on information received from one actuarial firm and two academic researchers. One researcher concluded, based on his simulations, that if 5 to 10 percent of Medicare enrollees switched to the most efficient physicians, savings would be 1 to 3 percent of program costs—which would amount to about \$5 billion to \$14 billion in 2007.

The Congress has also recently expressed interest in approaches to constrain the growth of physician spending. The Deficit Reduction Act of 2005 required the Medicare Payment Advisory Commission (MedPAC) to study options for controlling the volume of physicians' services under Medicare.¹¹ One approach for applying volume controls that the Congress directed MedPAC to consider is a payment system that takes into account physician outliers.

In our report on which this statement is based, we sought information about other purchasers' profiling efforts designed to encourage physicians to practice efficiently. 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.¹² 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.¹³ 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.

¹¹MedPAC is an independent federal body established by the Balanced Budget Act of 1997 to advise the Congress on payment, access, and quality issues affecting the Medicare program.

¹²In our report we used the term 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.

¹³Generally, estimates of an individual's expected spending are based on factors such as patient diagnoses and demographic traits.

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

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 selected areas that were diverse geographically and in terms of Medicare spending per beneficiary.¹⁴ We focused our analysis on generalists—physicians who described their specialty as general practice, internal medicine, or family practice. Although we did not include specialists in our analysis, our method does not preclude profiling specialists, as long as enough data are available to make meaningful comparisons across physicians.

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 areas according to their health status, using diagnostic and demographic information. We classified beneficiaries as overly expensive if their total Medicare expenditures—for services provided by all health providers, not just physicians—ranked in the top fifth of their health status cohort for 2003 claims.¹⁵

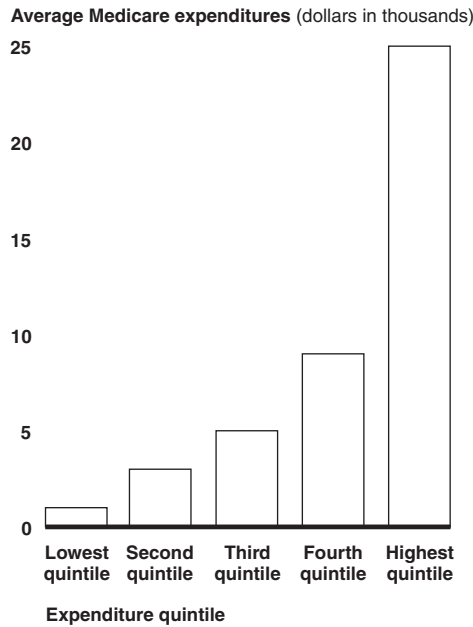
Within each health status cohort, we observed large differences in total Medicare spending across beneficiaries. For example, in one cohort of beneficiaries whose health status was about average, overly expensive beneficiaries—the top fifth ranked by expenditures—had average total expenditures of \$24,574, as compared with the cohort’s bottom fifth, averaging \$1,155.¹⁶ (See fig. 1.)

¹⁴The 12 metropolitan areas were Albuquerque, N.M.; Baton Rouge, La.; Des Moines, Iowa; Phoenix, Ariz.; Miami, Fla.; Springfield, Mass.; Cape Coral, Fla.; Riverside, Calif.; Pittsburgh, Pa.; Columbus, Ohio; Sacramento, Calif.; and Portland, Maine.

¹⁵Expenditures identified were for services from inpatient hospital, outpatient, skilled nursing facility, physician, hospice, durable medical equipment, and home health providers.

¹⁶See [GAO-07-307](#), appendix I, for a depiction of beneficiary expenditures at the 20th, 50th, and 80th percentile for each health status cohort.

Figure 1: Average Medicare Expenditures, by Quintile, for Beneficiaries of Nearly Average Health Status



Source: GAO analysis of 2003 Medicare claims and enrollment data.

Note: Beneficiaries who died during 2003 are excluded.

This variation may reflect differences in the number and type of services provided and ordered by these patients' physicians as well as factors not under the physicians' direct control, such as a patient's response to and compliance with treatment protocols. Holding health status constant, overly expensive beneficiaries accounted for nearly one-half of total Medicare expenditures even though they represented only 20 percent of beneficiaries in our sample.

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. Notably, all physicians had some overly expensive patients in their Medicare practice, but outlier physicians had a

much higher percentage of such patients. We concluded that these outlier physicians were likely to be practicing medicine inefficiently.¹⁷

Based on 2003 Medicare claims data, our analysis found outlier generalist physicians in all 12 metropolitan areas we studied. The Miami area had the highest percentage—almost 21 percent—of outlier generalists, followed by the Baton Rouge area at about 11 percent. (See table 1.) Across the other areas, the percentage of outliers ranged from 2 percent to about 6 percent.

Table 1: Percentage of Outlier Physicians in 12 Metropolitan Areas, 2003

Metropolitan area	Percentage of outlier physicians
Miami, Fla.	20.9
Baton Rouge, La.	11.2
Cape Coral, Fla.	6.3
Portland, Maine	5.8
Riverside, Calif.	5.8
Phoenix, Ariz.	5.2
Sacramento, Calif.	5.2
Des Moines, Iowa	4.8
Columbus, Ohio	4.6
Pittsburgh, Pa.	3.8
Springfield, Mass.	2.9
Albuquerque, N. Mex.	2.0

Source: GAO analysis of 2003 CMS claims and enrollment data.

Note: Outlier percentages greater than 1 percent indicate that an area has an excessive number of outlier physicians.

In 2003, outlier generalists' Medicare practices were similar to those of other generalists, but the beneficiaries they treated tended to experience higher utilization of certain services. Outlier generalists and other generalists saw similar average numbers of Medicare patients (219 compared with 235) and their patients averaged the same number of office visits (3.7 compared with 3.5). However, after taking into account beneficiary health status and geographic location, we found that beneficiaries who saw an outlier generalist, compared with those who saw

¹⁷Our approach to estimating outlier physicians was conservative in that it captured only the most extreme practice patterns; therefore, our analysis does not mean that all nonoutlier physicians were practicing efficiently.

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.¹⁸

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 FFS 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.

¹⁸These findings were derived from logistic regressions in which health status, geographic area, and beneficiary contact with an outlier generalist were the explanatory variables used to predict whether a beneficiary was hospitalized, used home health services, or was admitted to a skilled nursing facility.

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- *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, a methodological tool that assigns individuals a health status score based on their diagnoses and demographic characteristics. For example, CMS has used increasingly sophisticated risk adjustment methodologies over the past decade to set payment rates for beneficiaries enrolled in managed care plans. On the related topic of measuring resource use, CMS noted in comments on a draft of our report that emerging “episode grouper” technology was a promising approach to measuring resource use associated with a given episode of care. We agree, but we also consider our measurement of resource use on a per capita basis, capturing total health care expenditures for a given period of time, equally promising.

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 define inefficient practice patterns.

As for ways CMS could use profiling results, actions taken by other health care purchasers we interviewed may be instructive in suggesting future directions for Medicare. For example, all purchasers in our study used physician education as part of their strategy to change behavior. Educational outreach to physicians has been a long-standing and widespread activity in Medicare as a means to change physician behavior based on profiling efforts to identify improper billing practices and potential fraud. Outreach includes letters sent to physicians alerting them to billing practices that are inappropriate.¹⁹ In some cases, physicians are given comparative information on how the physician varies from other physicians in the same specialty or locality with respect to use of a certain service.

¹⁹Other forms of physician education include face-to-face meetings, telephone conferences, seminars, and workshops.

A physician education effort based on efficiency profiling would therefore not be a foreign concept in Medicare. For example, CMS could provide physicians a report that compares their practice's efficiency with that of their peers. This would enable physicians to see whether their practice style is outside the norm. In its March 2005 report to the Congress,²⁰ MedPAC recommended that CMS measure resource use by physicians and share the results with them on a confidential basis. MedPAC suggested that such an approach would enable CMS to gain experience in examining resource use measures and identifying ways to refine them while affording physicians the opportunity to change inefficient practices.²¹ In commenting on a draft of our report, CMS noted that the agency would incur significant recurring costs in developing reports on physician resource use and disseminating them nationwide. We agree that any such undertaking would need to be adequately funded.

Another application of profiling results used by the purchasers we spoke with entailed sharing comparative information with enrollees. CMS has considerable experience comparing certain providers on quality measures and posting the results to a Web site. Currently, Medicare Web sites with comparative information exist for hospitals, nursing homes, home health care agencies, dialysis facilities, and managed care plans. In its March 2005 report to the Congress, MedPAC noted that CMS could share results of physician performance measurement with beneficiaries once the agency gained sufficient experience with its physician measurement tools.

Several structural features of the Medicare program would appear to pose challenges to the use of other strategies designed to encourage efficiency. These features include a beneficiary's freedom to choose any licensed physician permitted to be paid by Medicare; the lack of authority to exclude physicians from participating in Medicare unless they engage in unlawful, abusive, or unprofessional practices; and a physician payment system that does not take into account the efficiency of the care provided. Under these provisions, CMS would not likely be able—in the absence of additional legislative authority—to assign physicians to tiers associated

²⁰MedPAC, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2005).

²¹In several testimonies before the Congress in the last half of 2005, CMS officials said that they were taking steps to implement this recommendation. See *Value-Based Purchasing for Physicians Under Medicare: Hearing Before the House Subcommittee on Health, Committee on Ways and Means, 109th Cong. (2005)* (statement of Mark B. McClellan, MD, Ph.D., Administrator of CMS).

with varying beneficiary copayments, tie fee updates of individual physicians to meeting performance standards, or exclude physicians who do not meet practice efficiency and quality criteria. In commenting on our draft report, CMS was silent with regard to the need for legislative authority. The agency noted that it is studying and implementing initiatives that link assessment of physician performance to financial and other incentives, such as public reporting.

Regardless of the use made of physician profiling results, the involvement of, and acceptance by, the physician community and other stakeholders of any actions taken is critical. Several purchasers described how they had worked to get physician buy-in. They explained their methods to physicians and shared data with them to increase physicians' familiarity with and confidence in the purchasers' profiling. CMS has several avenues for obtaining the input of the physician community. Among them is the federal rule-making process, which generally provides a comment period for all parties affected by prospective policy changes. In addition, CMS forms federal advisory committees—including ones composed of physicians and other health care practitioners—that regularly provide it with advice and recommendations concerning regulatory and other policy decisions.

Having considered the tools CMS has available and the structural challenges the agency would likely face in seeking to implement certain incentives used by other purchasers, we recommended in our April 2007 report that the Administrator of CMS develop a profiling system—seeking legislative authority, as necessary—that includes the following elements:

- total Medicare expenditures as the basis for measuring efficiency,
- adjustments for differences in patients' health status,
- empirically based standards that set the parameters of efficiency,
- a physician education program that explains to physicians how the profiling system works and how their efficiency measures compare with those of their peers,
- financial or other incentives for individual physicians to improve the efficiency of the care they provide, and
- methods for measuring the impact of physician profiling on program spending and physician behavior.

Concluding Observations

Policymakers have expressed interest in linking physician performance to Medicare payment so that incentives under FFS for physicians to practice inefficiently can be reversed. In our view, Medicare should adopt an approach that relies not only on physician education but also financial or other incentives—such as discouraging patients from obtaining care from physicians who are determined to be inefficient. 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 any 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 Phyllis Thorburn, Assistant Director; Todd Anderson; Hannah Fein; Richard Lipinski; and Eric Wedum.

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