

**AMERICAN COLLEGE OF RHEUMATOLOGY  
POSITION STATEMENT**

**SUBJECT:** Efficiency Ratings

**PRESENTED BY:** Committee on Rheumatologic Care

**FOR DISTRIBUTION TO:** Members of the American College of Rheumatology  
Medical Societies  
Medicare Carriers/Private Insurers  
Members of Congress

**BACKGROUND:**

1 Efficiency ratings, otherwise known as efficiency of care profiles, have increasingly been utilized by insurance  
2 companies to exclude providers from plans, and there has been call for more widespread and formal use. The  
3 American College of Rheumatology (ACR) is concerned that they have been used to exclude providers based on  
4 cost alone, and that validation of their utility to benefit both cost and medical care has yet to be demonstrated.  
5

6 The ACR recommends the following considerations when adopting efficiency of care profiles:  
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8 Cost comparison should not be adopted without the incorporation of outcome quality.

9 Cases have already occurred of insurance companies excluding providers from a cost standpoint alone. Less  
10 expensive medical care is not necessarily better care. An insurance company that utilizes cost comparisons must  
11 also measure a validated quality measure. It is important that the interests of the patient's health not be left out  
12 when discussing medical costs. The validated quality measure should be defined by an established non-biased  
13 entity, such as the National Quality Forum. It is unacceptable to make a decision based on cost alone, without  
14 incorporating the benefit of treatment.  
15

16 The scope of cost measurement should adequately reflect true cost of a condition.

17 The cost of a medical condition is not only limited to the direct costs of office fees, tests, and medications related to  
18 the condition ordered by the designated treating physician. The cost of a condition can also involve the indirect  
19 costs of utilization of other services when the condition has not been adequately treated. For example, an initial visit  
20 to a rheumatologist to treat gout might be more expensive than a visit to a non-rheumatologist. However, a patient  
21 incorrectly treated by a non-rheumatologist might incur later emergency room visits, days missed of work, and  
22 hospital stays due to recurrent gout flares, resulting in a larger total cost than if they had been treated correctly and  
23 had the flares prevented. The scope of cost measurement should encompass indirect costs such as utilization of  
24 emergency rooms, hospital stays, and related complications.  
25

26 Also, an incorrect diagnosis can also give an inaccurate assessment of cost. Gout is often falsely diagnosed by non-  
27 rheumatologists, and patients are started on unnecessary medications. Cost measurement should also incorporate the  
28 cost savings of an accurate diagnosis versus false positive and false negative diagnosis.  
29

30 A broad scope of the cost of a medical condition, involving direct and indirect costs, must be measured to ensure  
31 fairness in cost comparison.  
32

33 The comparison groups used should be fairly matched.

34 Efficiency ratings have already been used to compare rheumatologists to primary care physicians. Rheumatologists  
35 are trained to treat patients that can be sicker and have more complex diseases than the routine patient seen in a  
36 primary care setting. Therefore it is expected that costs might be higher when treating more complicated scenarios.  
37 Rheumatologists should only be compared to other rheumatologists.  
38

39 Also, among rheumatologists, the severity of illness in the patients treated might also vary. One practice might  
40 specialize in treating sicker patients, such as those with lupus nephritis, while another practice might refer those  
41 patients to another specialist. In addition, rheumatology practices can vary widely in their structure. One group  
42 might have on-site ancillary services, such as radiology and infusion, while another practice might utilize the same

43 services off site. This can make for an appearance of variance on the amount spent on a patient, when none exists.  
44 Insurance companies must show that efficiency comparison groups are similar. Efficiency comparison groups must  
45 be matched for diseases treated, severity of illness, and practice structure.

46  
47 Cut-off values in efficiency ratings should be validated and reasonable.

48 In one instance of inappropriate use of efficiency ratings, any provider who fell in the above average range for cost  
49 was excluded from an insurer, which equated to a large number of providers. In statistics, a normal distribution of  
50 any quality, such as height, follows a natural curve with some individuals expectedly lying farther from average than  
51 others. For example, just because a person is taller than average does not mean they have a disease of height. Using  
52 similar logic, just because a physician's cost might be out of the normal range does not necessarily mean their  
53 treatment is inappropriate or inefficient. In statistics a certain amount of variance is expected. If an efficiency rating  
54 is going to be used to exclude a provider, a validated method must demonstrate that the cut off value correlates with  
55 inefficient care. Efficiency rating cut off values should not be arbitrary.

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57 Approved by the Committee on Rheumatologic Care: 01/2010

58 Approved by the Board of Directors: 02/2010

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