

Policy experts suggest reduction of geographic variation as a means for dealing with Medicare funding gap.

Overview

This policy paper outlines a strategy for Medicare reform that addresses both spending and quality by identifying and reducing unwarranted variations in care.

Background

Per capita Medicare payments vary as much as two-fold across the country, even after adjustment for age, sex and race. These regional variations persist after adjustment for regional price differences.

Objective

To propose an approach to Medicare reform that addresses both spending and quality concerns.

Geographic Variation in Medicare Spending

The authors created an “illness index” to quantify the underlying disease burden among Medicare beneficiaries in a given region. They found that the underlying disease burden varied across regions but explained only 27 percent of the variation in spending. Other studies have confirmed that regional variations in Medicare use and spending often do not correlate with need for services.

Patterns of Medicare Spending in High-Spending Regions

The authors investigated the differences in practice patterns in the high-spending regions by examining three categories of services:

- **Effective care:** includes services whose use is supported by medical theory and clinical evidence and that virtually all patients should want as part of their health care systems (eg, eye examinations for diabetics). Evidence has shown that use of these services varies greatly by region and that most regions show underuse. In fact, underuse is present to the same degree in high-spending and low-spending regions.

- **Preference-sensitive care:** includes services in which two or more valid treatment choices are available for most patients. For these services, treatment choices should be based on well-informed patients making decisions based on the best available evidence. However, in practice use of these services often is determined by local practice patterns that are idiosyncratic and not related to physician supply.
- **Supply-sensitive care:** includes services for which there is little medical theory or medical evidence to guide use (eg, criteria for admission to intensive care units) and a high per capita supply of associated resources (eg, number of ICU beds). A greater supply of resources correlates with more frequent use of these services.

Previously known about the topic:

- Regional variations in Medicare spending are related to variations in provider practice patterns.

Contribution of this study:

- The authors propose a new approach to Medicare reform that would address spending and quality issues by promoting shared decision-making and establishing centers of medical excellence.

Relationship Between Quality Measures and Health Outcomes

According to the authors, there is a strong association between higher spending and greater use of supply-sensitive care, but a lack of association between higher spending and greater use of either preference-sensitive care or effective care. The authors point to evidence from several published studies showing that the greater spending associated with supply-sensitive care does not result in better health outcomes.

Potential Cost Savings and Proposed Strategies for Reform

The authors calculate that if regions with higher Medicare spending were brought into alignment with spending the levels of low-cost regions, the savings would represent almost 30 percent of Medicare spending. To achieve this spending, the government could simply impose spending caps on high-cost regions. However, this approach would not address the quality of care. Instead the authors propose a new approach to Medicare reform that would address both spending and quality.

The authors believe that strategies for reform must:

- Ensure that effective care is provided and medical errors are minimized.
- Improve the quality of patient-provider decisions about preference-sensitive conditions.
- Promote accountability for capacity and conservative practice in situations in which more care is wasteful and possibly harmful.

The authors propose a structure for reform that relies on the development of Comprehensive Centers for Medical Excellence (CCMEs). To establish a CCME, hospitals, provider networks, and organizations representing regional coalitions collaboratively agree on a best practice process that would reduce variations in care. These CCMEs would partner with Medicare, AHRQ and the NIH to develop the infrastructure needed to make fundamental improvements in the US health care system. As a first step, the authors suggest a demonstration project to evaluate the effectiveness of the proposed partnership.

The authors believe that this approach to Medicare reform would:

- Promote effective care and patient safety.
- Reduce unwarranted variation in preference-sensitive care.
- Reduce overuse of supply-sensitive care.

- Refine monitoring systems.
- Reward more efficient resource use.
- Promote widespread implementation of best-practice models.

Key Implications

- Regional differences in Medicare use and spending often do not correlate with need for services.
- A strong association exists between higher spending and greater use of supply-sensitive care. There is no such association between higher spending and greater use of either preference-sensitive care or effective care. Greater spending associated with supply-sensitive care does not result in better health outcomes.
- If regions with higher Medicare spending were brought into alignment with spending levels of low-cost regions, the savings would represent almost 30 percent of Medicare spending.
- The authors propose a new approach to Medicare reform that would address spending and quality issues by promoting shared decision-making and establishing centers of medical excellence.
- As a first step, the authors suggest a demonstration project to evaluate the effectiveness of the proposed approach to reform.

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